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SUBJECT INDEX

PAGE

A-B-C's of Sulfonamide and Antibiotic Therapy (Review) Long 697
Act of Incorporation, Providence Medical Association, 1887 33
Acute Ascending Paralysis 556
Adenocarcinoma of the Breast 44
Admission to Medical Schools 186
Advances in Internal Medicine (Review) Doc and Snapper 697
Advances in Military Medicine (Review) 275
Africa 246
American Academy of Pediatrics Child Health Services Study 411
American Cancer Society, Fellowships 433
A M A, assistant Secretary 348
A M A, Council on Emergency Medical Service 401
A M A, General Practitioner Award, Rhode Island Nomination 58
A M A, House of Delegates, Interim Session, Report of Delegate 208
A M A, June Meeting 268
Anesthesia in Obstetrics 489, 723
Anesthesia in Rhode Island 37
Ashworth, Charles J. (Photo) 310
Atomic Medicine 430
Azotemia, Prerenal 372

Batchelder, Philip (Photo) 140
(The) Battle of the Conscience (Review) Bergler 412
Beryllliosis 719
Bilateral Non-Simultaneous Femoral Arterial Embolic Occlusion 669
Blood and Plasma in Surgical Emergencies 291
(The) Blue Cross-Blue Shield Merger (Ed.) 674
Bradley, Charles (Ed.) 248
Breast, Adenocarcinoma of the 44
Butler Hospital, Board of Trustees — Minute Adopted on Retirement of Dr. Ruggles 492
Butler Hospital, Psychological Laboratory 52

Cancer Conference (Ed.) 731
Cancer Conference for Rhode Island Physicians (Program) 619
Cardiac Children 699
Case Finding in Tuberculosis (Ed.) 730
Cash Sickness, Sample Study of Claims 744
Centennial (See Providence Medical Association)
Ceppi, Charles B. (Photo) 310
(The) Challenge of Medicine in the Atomic Era 430
Changes (Ed.) 730
(The) Chapin, C. V., Fellowship (Ed.) 496
(The) Chapin Medal (Ed.) 307
Chapin Oration, The Seventh Annual (Industrial Health) 483

PAGE

Chase, Peter P. (Photos) 311, 443
Chesebro, Edmund D. (Photo) 58
Cholesteral Tolerance 103
Ciarla, Philomen P. (Photo) 195
Clinical Laboratory Methods and Diagnosis (Review) Grandwohl 748
Colitis, Chronic Ulcerative 663
College of Surgeons, New Fellows from Rhode Island 743
(Some) Common Misconceptions Regarding Dermatology 272
Community Leadership (Ed.) 249
Congenital Malformations (Review) Murphy 748
(The) Conquest of Puerperal Infection 1846-1946 235
Continuous Lumbar Peridural Anesthesia in Obstetrics 489
Correlative Neuroanatomy (Review) McDonald and others 698
Crawford Allen Hospital (Ed.) 306
Cutts, Morgan (Photo) 310

Dermatology, Some Common Misconceptions 272
Diseases of the Chest (Review) Rubin 696
Diseases of the Nose, Throat and Ear (Review) Ballenger 76
(The) Doctor's Role in Community Programs 562
Draft of Physicians (Proposed) 382

Effective Procedures in the Treatment of Injured Hands to Prevent Crippling Deformities 603
Embolism Peripheral Arterial 669
Endocarditis, Subacute Bacterial 302
(The) Etiology and Treatment of Chronic Ulcerative Colitis (Non-specific) 663
(In the) Event of a National Emergency 401
(An) Excursion Among the Eponyms (Ed.) 112
Exhibitors, 137th Annual Meeting 275
Extra-Mural and Intra-Mural Practice — Then and Now 363

Farrell, John E. (Photo) 310
Femur, Fracture of Upper End 48
(The) Fiske Fund (Ed.) 496
Fistulae, Vesicovaginal and Their Surgical Treatment 547
Fitz, Reginald (Citation) 275
Fox, G. Raymond (Photo) 310
Fractures of the Shaft of the Tibia 299
Fundamentals of Staff Organization 437

General Endocrinology (Review) Turner 696
(The) General Practitioner in New England Hospitals 498
General Practitioner Today, Position of 167
Gerber, Isaac, Oration 324
Gerber, Isaac, (Photo) 325
Gerber, Isaac, Response 325

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SUBJECT INDEX

PAGE

Germany, Surgery (Ed.) 672
Graduate Medical Education and Hospital Economics 177
Group Medical Practice 114

Hands, Injuries 603
Health in Providence — 1947 345
Health Insurance Committee — report to the House of Delegates 378
Health Programs, Modern 550
Heart Disease — Rheumatic Fever, Symposium on 243
Hospital Administrator, Responsibility to other Community Health Agencies 250
Hospital Association of Rhode Island 74
Hospital Economics (Graduate Medical Education) 177
Hydrocele, a new Technique in the Radical Cure of 433

Industrial Health, Eighth Annual Congress, Report of Delegate 134
Industrial Health, Seventh Annual Charles V. Chapin Oration 483
Internal Medicine in Central Europe (Ed.) 728
Internal Medicine in General Practice (Review) McCombs 214
Intern Training in the Hospital System 201
In the Event of a National Emergency (a report) 401

Kenney, The John F., Clinic of the Memorial Hospital Internes' Alumni Association 614
Kent County Hospital (Ed.) 185
Photo 273
Kent County Medical Society Meetings 68,192,262, 327, 397, 676

Leadership (Medical) 369
Leaves Off the Tree (Centennial Oration) 171

Malpighi Medical Club 743
Manual of Pharmacology (Review) Sollmann 638, 696
Medical Examiner System, Rhode Island 126
Medical Leadership (Presidential Address) 369
Medical Library Notes 530, 616, 740
Medical Schools, Admission to 186
Medical Statistics in Hospitals 580
Medical Teachers (Ed.) 495
Medical Writing (Review) Fishbein 638
Minor Surgery (Review) Christopher 340
Modern Health Programs 550
Museums, Health 723
Myxedema and Psychosis 725

(The) National Mental Health Act (Ed.) 612
Navy Pollution in Narragansett Bay (Ed.) 375
Necrology, Rhode Island Medical Society, 1947 80
Neurological Aspects of Poliomyelitis 427
New England Hospitals, General Practitioners in 498
New England Industrial Conference (Notice) 316
New England Postgraduate Assembly (Seventh) 643
Newport County Medical Society Meetings 143, 192, 326, 452, 676
(A) New Technique in the Radical Cure of Hydrocele 433

Observation and Diagnosis (Ed.) 494
O Connell, Joseph C. (Photo) 308, 443
Office Hours Wednesday 264
Overtreatment and Gunshot Prescriptions (Ed.) 247
Paralysis, Acute Ascending 556
Participating Physicians (Rhode Island Plan) 318, 448, 493, 701
(The) Pattern was Established, Presidential Address 107
Pawtucket Medical Association Meetings 73, 144, 262, 326, 397, 452, 678, 738
Pediatric Meeting 216
"Pediatrics" (Ed.) 307
Pharmacology, Therapeutics and Prescription Writing (Review) Bastedo 215
Physical Examinations for National Service Life or United States Government Life Insurance 637
Physicians Needed for Draftee Examinations 496
Physician Wanted 616
Plasma and Blood in Surgical Emergencies 291

PAGE

Pneumococcic Lobar Pneumonia 99
Pneumonia not Responding to Penicillin 609
Poliomyelitis, Neurological Aspects of 427
Poliomyelitis, Treatment of Bulbar (Ed.) 439
Pollution (Navy) in Narragansett Bay (Ed.) 375
(The) Position of the General Practitioner Today 167
Postgraduate Medical Education in Rhode Island 332
Potter, Edgar S. (Photo) 311
Practise of Allergy (Review) Vaughn and Black 639
Practise, Extra Mural and Intra Mural, Then and Now 363
Primer of Cardiology (Review) Burch and Reaser 338
Profound Prerenal Azotemia Resulting from Pyloric Stenosis 372
Proposed Draft of Physicians 382
Providence in 1848 56
Providence City Health Department 1856-1948 34
Providence Daily Journal Items, Issues of 1848 35, 78
Providence Health Department Statistics, Preliminary Report, 1947 345
Providence Medical Association 1848-1948 15
Providence Medical Association
Act of Incorporation 33
Annual Reports, 1947 146
Centennial (Ed.) 42, 110, 184
Centennial Dinner (Photos) 176
Centennial Window Displays (Photos) 269
Distinguished Service Awards 274
Golf Winners 680
Medical Milk Commission Report (1947) 148
Meeting Minutes 70, 140, 195, 262, 328, 398, 678, 738
Minutes of First Meetings 32
Officers, 1848-1948 61
Pioneers of the Providence Medical Association 31
Resolution Honoring Reginald Fitz 275
Roster of Committees, 1948 220
Providence Medical Journal, First Officers (Photos) 23
Providence, Tuberculosis 240
Psychological Laboratory at Butler Hospital 52
Psychosomatic Shift (Ed.) 307
Puerperal Infection, Conquest 235
Pyloric Stenosis, Resulting in Profound Prerenal Azotemia 372

Quanity Versus Quality (Ed.) 111

Record Librarians (Officers) 409
Report on the American Academy of Pediatrics Child Health Services Study 411
Research (Ed.) 248
(The) Responsibility of the Hospital Administrator to Other Community Health Agencies 250
Rheumatic Fever and Heart Disease, Symposium on 243
Rhode Island College of Pharmacy (Ed.) 183
(The) Rhode Island Hospital Staff Dinner (Ed.) 731
Rhode Island Medical Examiners System 126
Rhode Island Medical Society
Annual Dinner (Notices) 275
Annual Dinner (Speeches) 444
Annual Reports (1948) 456
Appointed Committees, 1948-1949 410
General Session 442
House of Delegates Meetings 62, 120, 388, 688
Meeting Notices 54, 701
Message of the President 309
Necrology, 1947 80
Officers and Elected Committees, 1948-1949 284
Officers—(Photos) 310, 311
Program—137th Annual Meeting 254
Roster of Fellows 620
Rhode Island Medicine—Its Problems and Its Solutions 512
Rhode Island Nomination for AMA General Practitioner Award 58
(The) Rhode Island Plan 312, 378
Participating Physicians in 318, 448, 493, 701
Roster Corrections 67
Ruggles, Arthur H., Retirement 492

SUBJECT INDEX

PAGE

Ruggles, Arthur H. (Photo) ... 443
Presentation of Gavel ... 448
Ruisi, John E. (Ed.) ... 613
Ruisi, John E. (Photo) ... 613

St. Joseph's Hospital—meeting notice ... 298
Seal of Approval (Ed.) ... 495
Sexual Behavior in the Human Male (Review) Kinsey ... 212
Siliform Ampuls (Warning) ... 583
Social Insecurity (Ed.) ... 559
Spinal Anesthesia in Vaginal Deliveries ... 723
State Cancer Conference (Ed.) ... 561
Staff Organization, Fundamentals of ... 437
Statement of Ownership of Rhode Island Medical Journal ... 613
Streptomycin in Tuberculosis (Ed.) ... 249
Subacute Bacterial Endocarditis ... 302
Superintendents of Health—Providence (Photos) ... 35
Surgery in Germany (Ed.) ... 672
Symposia on Nutrition of the Robert Gould Research Foundation (Review) ... 696
Symposium on Medicolegal Problems (Review) Levinson ... 338, 412
Symposium on Rheumatic Fever and Heart Disease ... 243

Textbook of Clinical Neurology (Review) Wechsler ... 212
Textbook of Medicine (Review) Cicil ... 76
Through the Microscope ... 684
Tibea, Fractures of the Shaft ... 299
Treatment of Bulbar Poliomyelitis (Ed.) ... 439
Truth and Circumstances (Ed.) ... 184

PAGE

Tuberculosis in Providence ... 240
Tuberculosis, Streptomycin ... 249
Tufts Alumni in Rhode Island Elect ... 260

Unipolar Lead Electrocardiography (Review) Goldberger ... 340

Vesicovaginal Fistulae and Their Surgical Treatment ... 547
Vidal, Jeannette E. (Photo) ... 192

Wanted by the FBI ... 584
War Memorials (Ed.) ... 561
War, Politics and Insanity (Review) Blumel ... 532
Wednesday Office Hours ... 264
Wells, Guy W. (Ed.) ... 440
Wells, Guy W. (Photo) ... 441
What Good Are Health Museums? ... 732
What's Wrong With the Profit Motive? (Ed.) ... 376
Wilms Tumor ... 105
Woman Physicians (Ed.) ... 183
Woman's Auxiliary, Committee Appointments 1948-1949 ... 529
Woman's Auxiliary
Meeting Notices ... 41, 270
Membership Drive ... 185
Proposed Revision to Constitution and By Laws ... 270
Second Annual Convention ... 408
Report of March Meeting ... 407
Woonsocket Medical Society Meeting Minutes ... 68, 327
Workmen's Compensation Law ... 130

(The) Years after 50 (Review) Johnson ... 215
You and Your Doctor (Review) Miller ... 343

AUTHOR INDEX

Bassler, Anthony ... 663
Beck, Aaron T. ... 372
Beck, Irving A. ... 76, 696, 697
Blood, Robert O. ... 566
Bloomer, George ... 112, 184, 494
Bortz, Edward L. ... 430
Bowman, R. O. ... 748
Brackett, Edward S. ... 235
Browne, William E. ... 603
Buffum, William P. ... 411
Burns, Frederick J. ... 103

Calder, Harold G. ... 699
Chapian, Mihran A. ... 105
Chase, Peter P. ... 15, 215, 638
Corrigan, Francis V. ... 245
Cutts, Morgan ... 609

DeJong, Helen ... 215
Donley, John E. ... 15
Drinker, Philip ... 483
Dufresne, Walter ... 489, 723

Eddy, Jesse P., 3rd ... 669

Farrell, John E. ... 401, 498
Faulkner, James M. ... 167
Feinberg, Banice ... 244
Field, E. A. ... 696
Fischer, William J. H. ... 638, 696, 697
Fish, David ... 532
Fitz, Reginald ... 171
Foley, William H. ... 338, 412

Gebhard, Bruno ... 732
Gerber, Isaac ... 325
Gordon, J. H. ... 300
Goldstein, S. S. ... 212
Greason, Thomas L. ... 212
Greenstein, Jacob ... 302

Hager, Herbert F. ... 214
Hamlin, Hannibal ... 698
Hammond, Roland ... 15
Harrington, Peter F. ... 240
Henry, Robert T. ... 299
Hill, Frederick T. ... 114
Hiscock, Ira V. ... 250
Hughes, William N. ... 412

Jackvony, Albert H. ... 401

Kelly, Earl F. ... 243
Kenney, John F. ... 245
Kingman, Lucius C. ... 275

Lagerquist, A. L. ... 343
Lawson, Herman A. ... 208
Leavell, Hugh ... 562
Levine, Samuel A. ... 363
Lewis, Robert V. ... 99

McLaughlin, Edward A. ... 550
McKiernan, J. S. ... 444
Miller, Albert H. ... 37
Miller, Henry ... 338, 340

Nunez, Mary ... 580

O'Connell, Joseph C. ... 309
Oddo, Vincent J. ... 433
O'Hara, Dwight ... 186

Pascal, Gerald R. ... 52
Payne, Edward B. ... 48, 76
Pearson, Rudolph W. ... 76
Perry, Thomas, Jr. ... 44, 340
Phaneuf, Louis E. ... 547
Potter, Charles ... 748
Pratt, Oliver G. ... 177

AUTHOR INDEX

	PAGE
Roberts, D. J.	446
Ruggles, Arthur H.	369
Scanlan, James J.	725
Smith, Joseph	34
Simeone, F. A.	291
Sterber, Perry	639
Sosman, M. C.	324
Sprague, Stanley	134
Umstead, Howard W.	489, 723
Viets, Henry R.	427
Weigner, Walter C.	556
Wells, Guy W.	107, 444
Wilkinson, Charles F., Jr.	437, 201
Wilson, J. W.	696
Wilson, Stanley A.	719

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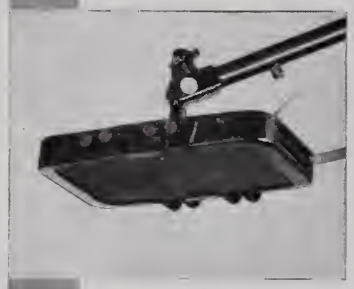
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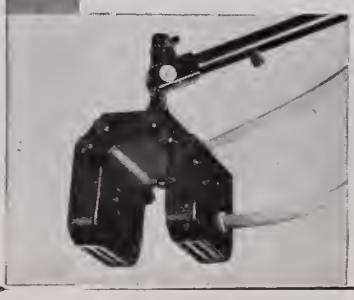
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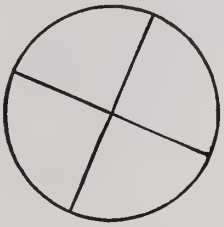
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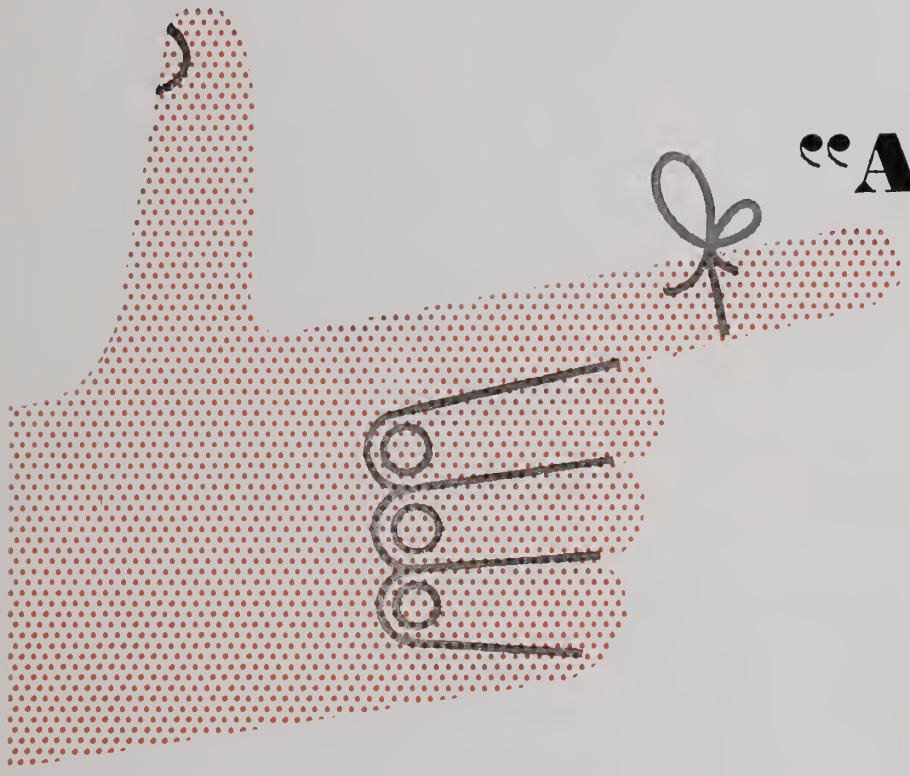
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Vol. XXXI, No. 1 January, 1948

TABLE OF CONTENTS

PAGE

The Providence Medical Association, 1848 . . . 1948, *Roland Hammond,* M.D., *John E. Donley,* M.D., *Peter Pineo Chase,* M.D. 15
Minutes of First Meetings of The Providence Medical Association 32
The Providence City Health Department, 1856—1948, *Joseph Smith,* M.D. 34
Anesthesia in Rhode Island, *Albert H. Miller,* M.D. 37
Adenocarcinoma of The Breast, Report of a Case, *Thomas Perry, Jr.,* M.D. 44
Fracture of The Upper End of The Femur, *Edward B. Payne,* M.D. 48
The Psychological Laboratory at Butler Hospital, *Gerald R. Pascal* 52
Providence in 1848 56

EDITORIALS

The Providence Medical Association Centennial 42

DEPARTMENTS

District Medical Society Meetings 68
Hospital Association of Rhode Island 74
House of Delegates, Report of November 24, 1947 62
Necrology, 1947, The Rhode Island Medical Society 80
Officers of The Providence Medical Association, 1848-1948 61
R. I. Nomination for AMA General Practitioner Award 58

MISCELLANEOUS

Act of Incorporation, Providence Medical Association, 1887 33
Book Reviews 76
Correspondence 76
Index of Advertisers 83
Providence Daily Journal Items, Issues of 1848 36 and 78
Woman's Auxiliary Meeting 41

PHOTOGRAPHS:

Office of Dr. H. W. Rivers 16, 17
Thomas Poynton Ives 20
Rhode Island Hospital 21
St. Joseph's Hospital 22
Dr. George D. Hersey 23
Dr. Frederic T. Rogers 23
Pioneers of the Providence Medical Association: (Drs. J. W. C. Ely, Geo. L. Collins, Lewis L. Miller, Lewis W. Clifford, Henry W. Rivers) 31
Providence Superintendents of Health, (Drs. Edwin M. Snow, Charles V. Chapin, Dennett L. Richardson, Michael J. Nestor) 35
Dr. Edmund D. Chesebro 58

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1. Dunn, H. L.: Am. J. Pub. Health 36:1412 (Dec.) 1946.

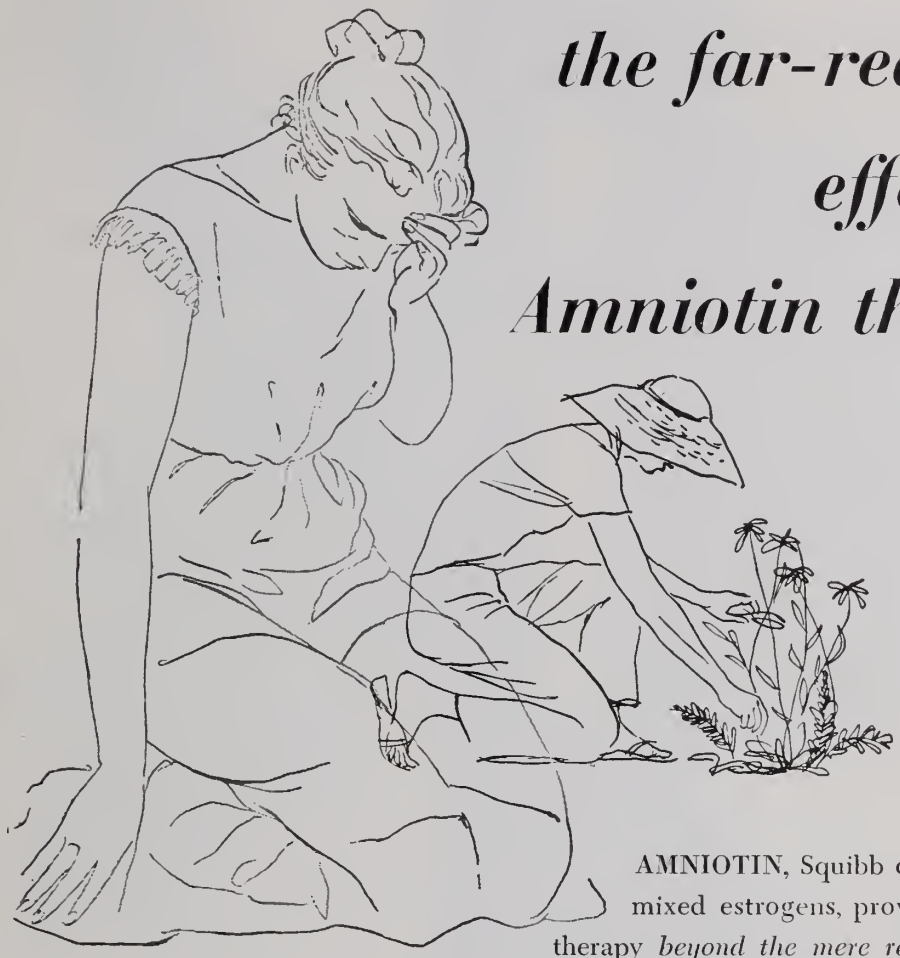
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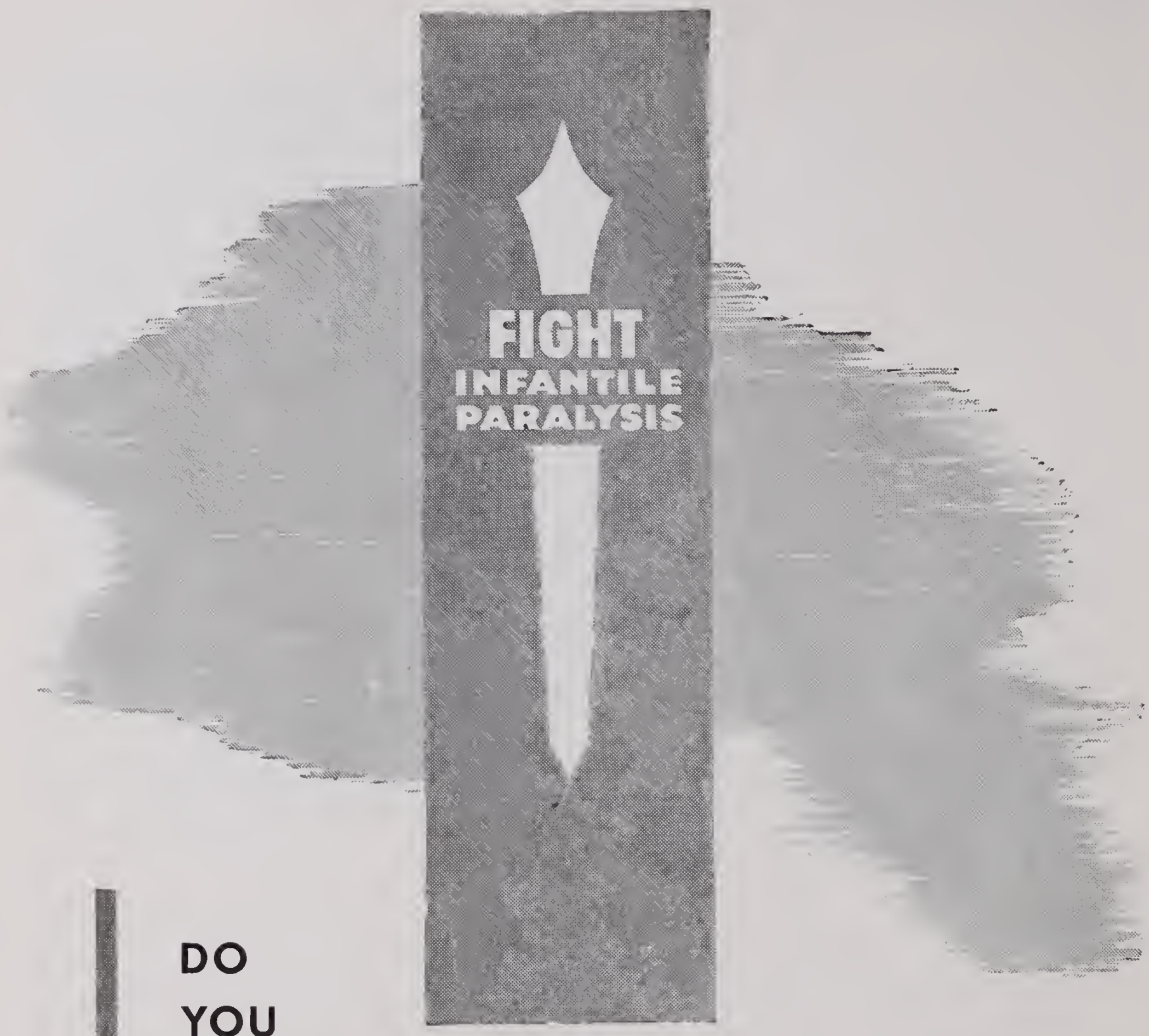
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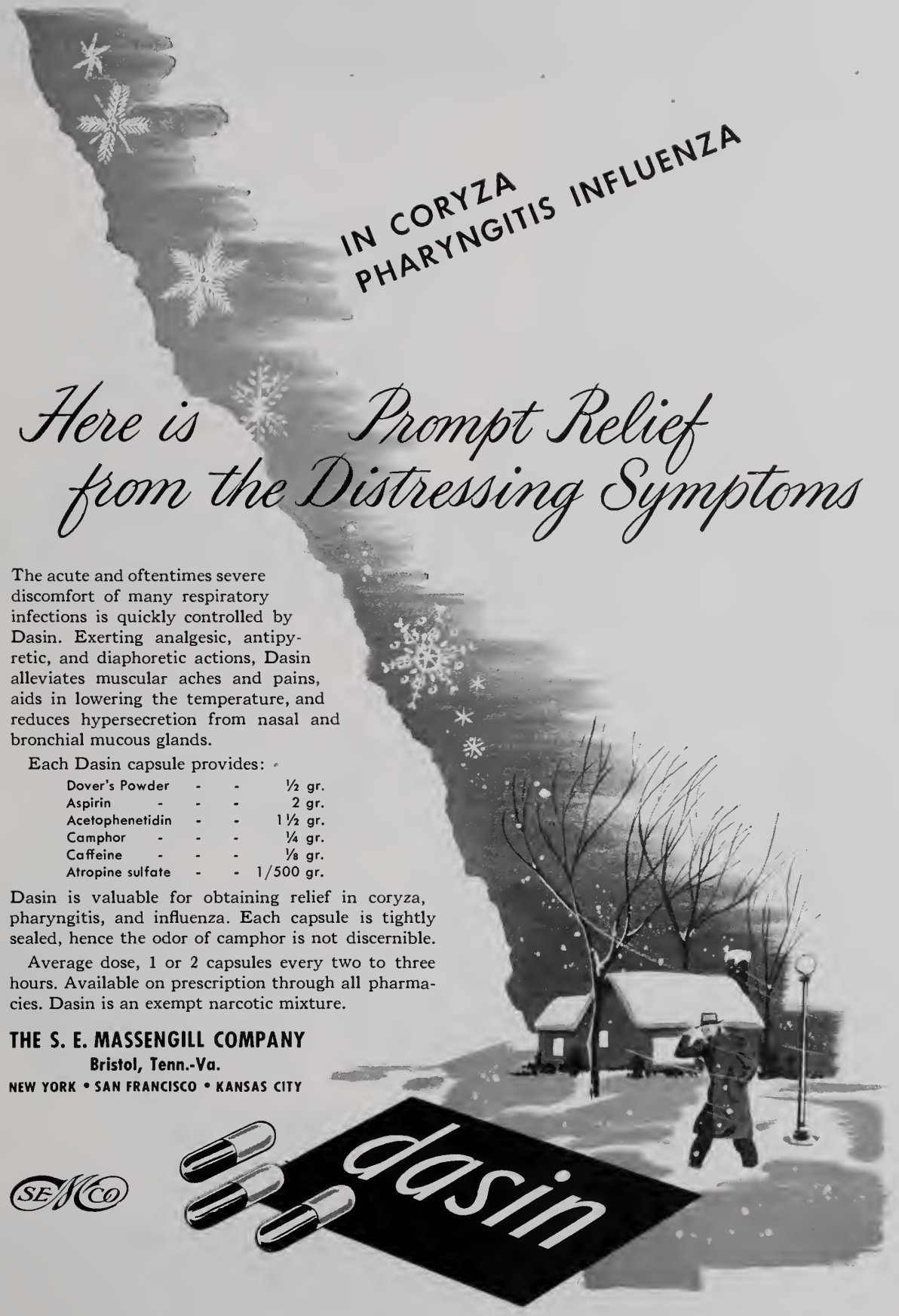
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THE PROVIDENCE MEDICAL ASSOCIATION

1848 1948

ROLAND HAMMOND, M.D., JOHN E. DONLEY, M.D., PETER PINEO CHASE, M.D.

ON THE EVENING of Monday, January 31, 1848, a few physicians of Providence — how many we do not know — met in the small office of Dr. H. W. Rivers on North Court Street, which still wends its straight and narrow way from Canal, across North Main to Benefit Street, along the northerly side of the old Central Police Station on Canal Street and the old State House on Benefit Street. At this meeting it was voted that a city Medical Society or Association should be formed for the mutual benefit of its members. Dr. S. Augustus Arnold was elected temporary Chairman and Dr. J. W. C. Ely, temporary Secretary. A Committee, composed of Doctors George L. Collins, H. W. Rivers and S. A. Arnold, was directed to draft a constitution and by-laws for the proposed Association. The meeting was then adjourned to the following Saturday evening, February 5, at the office of Dr. Joseph Mauran. Two things were accomplished at the second meeting. The constitution and by-laws suggested by the Committee were read and adopted, and the same Committee was continued with instructions to draw up a fee-table, together with such additions to the by-laws as might appear to be necessary. On February 14, the third meeting of the Association was held in the rooms of the Franklin Society. The fee-table was read and with some amendments adopted as part of the by-laws by the nine physicians present, Drs. Mauran, Arnold, Capron, Utley, Collins, Haszard, Miller, Pratt and Angell. Doctors Mauran, Arnold, Capron and Miller were appointed a committee to present the constitution and by-laws to the physicians of Providence for their signatures.

On March 6, 1848, in accord with the by-laws, the first annual meeting of the Association was held in the rooms of the Franklin Society. The following men were unanimously elected to office: President, Dr. S. Augustus Arnold; Vice-President, Lewis L. Miller; Treasurer, Lewis W. Clifford; Secretary, J. W. C. Ely; Standing Committee, Henry W. Rivers, Charles W. Parsons, George L. Collins, Edmund V. Hathaway and Henry B. Pratt.

The constitution sets forth that the objects of the Association shall be (1) the separation of regular and irregular practitioners; (2) the association of the profession proper, for the purposes of mutual recognition and fellowship; (3) the promotion of the character, interests and honor of the fraternity by maintaining the union and harmony of the regular profession of the City and aiming to elevate the standard of medical education; (4) the cultivation and advancement of the science by our united exertions for mutual improvement and our contributions to medical literature. For admission to the Association it was required that one must be a regular practitioner of medicine or surgery in the City of Providence and a Fellow of the Rhode Island Medical Society. It was provided, also, that "no proprietor or vendor of any patent or secret remedy or medicine nor any empirical or irregular practitioner, should be admitted to or retained in the Fellowship of this Association."

With these honorable ideals and standards, our medical forefathers launched their new Association; but since idealism without some tincture of realism is no adequate diet for the practitioner of medicine, we discover that the earliest meetings of the Association were devoted, for the most part, to the consideration of practical affairs, the principal subject of discussion being the problem of fees. The committee appointed at the second meeting to draw up a fee-table performed its duties with such commendable, not to say dramatic, promptness that one may be inclined to the suspicion that monetary motives played some part in the founding of the young Association. At any

continued on next page

rate, a tentative fee-table was presented for discussion at the third meeting held on Monday evening, February 14, in the rooms of the Franklin Society, then located in the basement of the Providence Athenaeum. Nine members of the Association were present, which was two more than the required quorum of seven. We are informed in the careful minutes of Dr. Ely that the fee-table was read, discussed, accepted and, with some amendments, adopted as article VI of the by-laws.

Fees for Medical Service

In these, our more lucrative days, it is perhaps a little difficult to realize that when the Association was born, the fee for medical services was fifty to seventy-five cents for a house visit and for an office visit twenty-five cents. Attendance on midwifery cases cost five to ten dollars; the very rich paid fifteen dollars and, in rare instances, even more. Among the physicians of the City there was no uniform rate of charges for like services; hence, the necessity for the establishment of a fee-table to bring order out of confusion. We should remember, however, that while the fees were small, physicians enjoyed a supplementary income — many of them dispensed their own medicines on which they often made a profit of three or four hundred percent — and at a period when militant therapeutics were the fashion, the patients of our medical forebears were supplied generously, no doubt, with calomel, jalap, black draught, emetics, cathartics and other equally potent remedies. In addition to all this, they were bled copiously and blistered freely upon the slightest provocation. In 1848, the people of Providence expected their physicians to be men of action, and rarely were they disappointed in their expectations.



In this building, located at the corner of Canal and North Court Streets, the physicians of Providence organized the Providence Medical Association. The arrow points to the door, (now boarded) of Dr. H. W. Rivers' office where the meeting was held the evening of January 31, 1848.

It may be of interest to note some of the fees adopted in the original table to which all members of the Association were required to conform. For a visit $1.00; for a visit in consultation $2.00; for a visit and passing a catheter $2.00; for a visit and dressing or venesection $1.00—$2.00; for a visit in the night $3.00—$5.00; for a visit out of town, for every mile from the center of Providence, $1.00; for an opinion involving a question in which a physician may be subpoenaed, $5.00; for a post-mortem examination in a case of legal investigation, not less than $10.00; for a case of gonorrhoea, not less than $10.00; for a case of syphilis, not less than $10.00; for a case of midwifery, $8.00; if any part of the attendance is in the night $8.00—$10.00; for using forceps, $12.00; for visit and cupping $2.00; for visit and vaccination $2.00; for vaccination at physician's house $1.00. Some of the fees for surgery were as follows: For capital operations, such as amputation of large limbs, lithothomy, trepaning and extirpation of large tumors, etc., $50.00—$100.00; for fistula-in-ano $10.00—$25.00; for tapping for dropsy and reducing luxations and fractures of large bones, $10.00—$40.00; for amputation of fingers and toes and extirpation of small tumors $3.00—$15.00; for reducing luxations or fractures of small bones, stitching recent wounds, opening abscesses, etc., $2.00—$10.00. At the meeting of July 3, 1848, it was voted to print for distribution one-hundred copies of the fee-table, together with the names of the members of the Association. In November, 1855, the fee-table was revised and amended. While most of the fees remained as before, there were small increases, as, for example, in midwifery during the day or the night an advance of $2.00 over the previous fees. In 1864, the fee for visits was raised to $1.50. In 1869, the charge for house visits within the City was from $2.00 to $5.00, office consultations $1.00 to $5.00, consultation visits $5.00 to $10,00, and ordinary obstetrical attendance, including three subsequent visits, $15.00 to $50.00.

In the by-laws the fee-table is followed by the statement that "It is not, however, designed by these regulations to prevent members of this Association from rendering their services to the poor gratuitously. And in cases where the physician believes his patients cannot afford to pay the regular fees and yet are able to make some remuneration, the physician may, in his discretion, deduct from the charge. But in all such cases it shall be the duty of the physician, by bill or otherwise, to in-

dicate the whole amount of value of the services rendered. These deductions shall not be made in the original charges." The fee-table of November 5, 1855, was accepted and signed by all of the twenty-four City members of the Association.

Medical Institutions Lacking

One hundred years ago, Providence, then a City of approximately forty thousand inhabitants and fifty doctors, was poorly supplied with medical institutions. Butler Hospital was opened for the reception of patients on December 1, 1847, with the celebrated Dr. Isaac Ray, the Nestor of psychiatrists, as its first Superintendent. The Dexter Asylum, at that time a more important and active medical institution than it became in later years, was the only place available to the City for the care of its sick poor. At the Asylum there were yearly about thirty births and about the same number of deaths. To make post-mortem examinations on all the dead was one of the most prized privileges of the medical staff, who often discovered interesting and unusual pathological conditions. The office of City Physician went with the appointment to the Asylum and the City Physician was obligated to attend all cases of smallpox and of typhus fever occurring at the Pest House, which stood where the Rhode Island Hospital now stands. The man who took care of the place furnished the food and nursing care, most of which he did himself. There was also the Providence Dispensary divided into two districts, East and West. In 1847, Dr. J. W. C. Ely was appointed physician to the East Side Dispensary, which he served for four years, and he tells us that he once had the curiosity to figure up his financial reward for Dispensary work during one year and found it to be 2½¢ per visit, including office calls.

Although nothing seems to have come directly from their efforts, nevertheless, the members of the Association were fully alive to the need for more adequate hospital facilities within the City. At the meeting of October 6, 1851, it was voted that "a committee of seven be appointed to take into consideration the propriety of establishing a hospital in this City and to take such measures for inquiry upon the subject as they may deem necessary and expedient thereto." The committee comprised the following physicians, who were directed to report at the next monthly meeting: Drs. Usher Parsons, Chairman, J. Mauran, L. L. Miller, R. Brownell, George Capron, S. Augustus Arnold and C. W. Fabyan. At the following monthly meeting the report of the committee was accepted and placed on file. Two years later, the subject of a hospital in the City was discussed again and on motion of Dr. Snow, the City's first Superintendent of Health, it was voted "that the committee appointed in October, 1851, be authorized and requested to take such measures as they may think expedient to further the object." Nothing more is heard of the hospital question until the June meeting of 1855, when Dr. Usher Parsons drew the attention of the Association to a recent statement in the Providence Journal reflecting unfavorably upon the "tardiness of the medical faculty of the City in moving in this matter"; whereupon it was voted that Dr. Parsons, as being Chairman of the committee, be requested to "take suitable notice of the subject stating its whole history." The next month, Dr. Parsons resigned from the committee and the records are again silent concerning the hospital project until the meeting of November 7, 1868, when it was voted that the librarian of the Providence Medical Association be instructed to transfer all the books, pamphlets and specimens belonging to the Association to the librarian of the Rhode Island Hospital and to furnish the Association a full catalogue of all the books, pamphlets and specimens thus transferred. At the next meeting, December, 1868, the above list was presented to the Association by its librarian, Dr. Brown.

continued on next page



Through this door, now boarded, the founders of the Providence Medical Association entered Dr. H. W. Rivers' office for their first meeting 100 years ago.

Scientific Meetings

To Dr. H. W. Rivers belongs the distinction of being the first to present clinical material before the Association. It is recorded that at the meeting of May 1, 1848, Dr. Rivers "exhibited to the Association a very interesting specimen of diseased femur, the disease occupying the condyles and extending into the shaft of the femur." At the following monthly meeting, Dr. Charles W. Parsons proposed the following resolution, which was passed, "that a committee of three be appointed by the chair to serve until the next annual meeting, whose duty it shall be to secure in advance performances of a scientific or practical character for each monthly meeting of the Association, if possible; these performances to consist in reports of cases or specimens or whatever in the opinion of the committee may be interesting or profitable to the members of this Association."

After the passage of this resolution, the indefatigable Dr. Rivers exhibited a specimen of reamputation of the tibia and fibula; also a specimen of fractured humerus of a goose "united by the efforts of nature." At the meeting of September 4, 1848, Dr. Capron read a paper on dysentery, which was very prevalent during the preceding summer and gave a verbal statement of the treatment which he had found most effective in arresting it. After Dr. Capron's presentation, Dr. Mauran and the other members present contributed remarks on dysentery and gave their experience as to its treatment. The immediately following meetings were concerned with the discussion of whooping-cough and of typhoid fever, during which Drs. Capron and Pratt exhibited to the members of the Association "a beautiful specimen of ulcerations of the small and large intestines taken from a patient dead of the latter disease." The use of the recently-introduced ether as an anesthetic must have aroused a lively interest, for the first two meetings of 1849 were occupied with the discussion of Etherization in Midwifery, upon which subject Dr. Mauran and the other members present gave the results of their experience with this agent.

Cholera was causing a great deal of public concern in the City during the summer of 1849. At the meeting of June 4, 1849, Dr. Arnold related the history and symptoms of a case of supposed cholera on Eddy Street. Dr. George L. Collins, who performed a post-mortem examination upon the patient, read a statement of the facts he had been able to gather with regard to the history, symptoms, treatment and lesions. On July 24, 1849, the Association held a special meeting, twelve members being present, at which it was voted that a committee of two be appointed to confer with the Board of Health in regard to reporting cases of cholera. It was voted, also, to recommend that all members of the Association should take notes of cases of cholera occurring in their practice and deposit these notes with the secretary. The committee on cholera reported later that "they had conferred with His Honor, the Mayor, the Board of Health not being in session, and represented to him the wish of the Association that no cases of cholera, except those ending fatally, be reported." With this suggestion of the Association the Mayor most willingly agreed, deeming the plan "decidedly the most judicious to allay public anxiety and panic." In June, 1854, cholera is again the subject for discussion and ten cases were reported, while in February, 1855, following a paper on cholera by Dr. E. M. Snow, the Association voted to recommend to the City Council that a Superintendent of Health be appointed. Dr. Snow was so elected in July, 1856, and served until 1884, when at his death, Dr. Chapin became his successor. At the regular meeting in June, 1866, and at an adjourned meeting one week later, cholera was discussed and Dr. Snow moved and it was voted, "Cholera is not contagious and all fears are unnecessary and foolish." Two months later, it was unanimously voted that Dr. Snow be given leave to withdraw his resolution of June, which he did.

Despite the small number of members present, the early meetings of the Association were, no doubt, both interesting and instructive. Even today, one should like to listen to Dr. George L. Collins as did the ten members who attended the meeting of July 1, 1850. At this meeting, he exhibited a number of specimens of pathological anatomy taken from recent post-mortems, among the most interesting of which were "schirrous of the pyloric orifice of the stomach extending into the duodenum; an enlargement of the head of the femur with destruction of the cartilage and a portion of the femoral artery in an ossified state, all taken from a patient who died from a schirrous affection; a portion of the frontal bone taken from a fractured cranium extending into the orbit of the eye; a portion of the vena cava ossified, producing an external venous tumor."

Dr. Collins exhibited, also, "a beautiful specimen of a hollow preparation of the heart dried in such a manner as to exhibit perfectly the valves in their natural situation. This was pronounced a masterpiece by all present as requiring great skill and care in its production and equal skill to produce its unusual beauty and perfection of finish."

At the subsequent meetings of 1851, Dr. Collins read his notes of a fatal case of narcotism in measles due to the injection of a tablespoonful of tincture of opium through the mistake of the nurse in attendance. Dr. Ely presented a number of specimens taken from recent subjects; two diseased

hearts, one of extensive ossific deposit, the other of perforation of the valves, a specimen of Bright's disease, a fibrous tumor of the uterus. Dr. C. W. Parsons exhibited a uterine tumor removed by the president of the Association, Dr. Usher Parsons. Dr. Mauran reported a case of "brain affection", Dr. Armington a case of effusion on the brain of a new-born infant, treated successfully by the use of hydriodate of potash, Dr. Usher Parsons the case of a woman who had swallowed six teeth attached to a gold plate which passed from the bowels without difficulty. In September, 1851, Dr. Collins exhibited under the microscope a beautiful specimen of minute injection of blood vessels, together with specimens of trichina spiralis in muscular tissue.

At the same meeting, Dr. Ely presented specimens of these parasites from the pectoral muscle and also some of the blood vessels from the brain of a patient who had died of apoplexy. Dr. Utley reported a case of extrauterine conception in which sixteen years later the remains of the foetus were found post-mortem.

In November, 1851, twelve members were present at the meeting and several of them made remarks upon the beneficial effects of electro-magnetism, while Dr. Fabyan related a case of neuralgia of the scalp apparently cured after the second electromagnetic treatment. Dr. Usher Parsons reported a case of uterine irritation apparently cured by electromagnetism, and Dr. Collins remarked upon the beneficial effects of electromagnetism in a case of strangulation of the small intestine. He was of opinion that this treatment helped to relieve the sufferings of the patient and assisted in exciting the peristaltic action of the bowels.

Treatment of Pneumonia

In 1852 and in the immediately-following years, the members of the Association continued the presentation and discussion of cases, some of them rare and unusual, all of them interesting and instructive, which had come under their observation. And how vastly different and remote from our own were many of the problems which engaged their attention! We read of animated discussions about dysentery, membranous croup, typhoid and typhus fevers, cholera infantum, scarlet-fever, erysipelas, infantile pulmonary phthisis, cholera, puerperal peritonitis, measles, pyemia and smallpox. On October 3, 1859, there was a debate as to the value of antiphlogistic treatment of pneumonia. Drs. Collins and Ely contended that pneumonia was a self-limited disease and that it was useless and worse than useless to attempt to break it up by the use of sedatives, depressants, bleeding, antimony and veratrum viride. Drs. Capron, Peckham and Baker were equally confident that these agents were of great value and quite effective in controlling the disease. Dr. Capron observed that during the many years he had been in the habit of bleeding, and bleeding freely, he had not, to his knowledge, lost a single middle-aged patient by pneumonia; and that since bleeding had become unfashionable, he had seen patients die and die, as he thought, because they had not been bled. Dr. Collins maintained that statistics would show that the "do nothing" treatment was followed by the best results. He did not understand the *modus operandi* of the sedative treatment. He inquired somewhat tartly, "Suppose you do lessen the rapidity of the circulation in the affected organ, do you thereby remove the condition which causes it?" This debate on the treatment of pneumonia had such practical implications and consumed so much time that its continuance was adjourned to a special meeting, one week later, in the office of Dr. Capron. The irrepressible and skeptical Dr. Collins produced some statistics on the treatment of pneumonia showing that in a given number of cases a greater percentage recovered without treatment than with bleeding and tartar emetic, to which Dr. Fenner Peckham replied that statistical records were of no real value because no special treatment was applicable to all cases and that while bleeding was best for one condition, it was the worst thing for another. He did not think that the results of the "do nothing" treatment compromised, in the least, the value of bleeding, tartar emetic, etc. in pneumonia. What conclusions were derived from this discussion the records do not relate, but it is probable that each of the contestants still held to his own opinion. Obviously, the question received no definite answer because we learn that ten years later, on April 5, 1869, the treatment of pneumonia was discussed again. Dr. Perry, after reviewing his practice, believed that he had met with greater success in treating this disease with tonics and stimulants than with mercury and bleeding. He had given up the use of expectorants, but continued to employ Dover's powder, nitrate of potash, punch and milk broths. Dr. Capron remarked that he had treated pneumonia successfully by stimulating and by depleting. He thought the proportion of deaths was much greater in his practice during the last fifteen years than it was formerly, before bloodletting went out of fashion. His old practice was to bleed early and to bleed until the patient was relieved of pain. He bled one patient five times and the patient recovered. He was of opinion that there was some change in the character of the disease and that bloodletting was not so well borne as formerly, but he still held to the opinion that there were many cases of a highly inflammatory character which would be benefited by early bleeding. Supporting Dr. Capron's conclusions, Dr. Chase Wiggin re-

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ported a case of pneumonia seen by him in which, according to his firm belief, bleeding saved the life of the patient.

To students of diabetes the case report by Dr. Smith at the September meeting of 1852 should be of no little interest. Dr. Smith proudly told his colleagues that he had successfully treated a diabetic patient by the administration of one pint of good old New England rum during every twenty-four hours, the treatment lasting about three months; a tribute, indeed, to one hardy Rhode Islander who withstood not his diabetes only, but also ninety pints of New England rum. That stammering may, on occasion, lead to untoward results is illustrated by a patient who came under the care of Dr. Baker. The patient applied to an apothecary in Providence for six 1-grain pills of opium, but was misunderstood by the apothecary so that he was given six 6-grain pills. After taking one pill, he consulted Dr. Baker, who prescribed a powerful emetic; no stupor followed and the man returned to New York. Shortly afterwards, his attorney wrote to the apothecary threatening him with a suit for damages because of illness alleged to have been due to the apothecary's negligence.

The October and November meetings of 1856 were spent pleasantly in the study of microscopic specimens for which the Association was indebted to Mr. T. P. Ives, Drs. Collins and Ely. The following specimens were exhibited: The circulation in a frog's foot; the motions of cilia from the oyster; nerve fibers and blood corpuscles, spermatazoa from the frog; transverse sections of the teeth and of the femur; muscular fibers. At the February meeting, 1858, Dr. Collins again exhibited several microscopic specimens, among which were urinary deposits, tubular casts from the kidneys, cancer cells and the itch insect. A few months later, he read an interesting paper on the microscope and its recent contributions to medical science, for which he was voted the sincere thanks of the Association.

In 1862, the first ovariotomy in Rhode Island was performed by Dr. Burnham, of Lowell, Massachusetts, upon a patient of Dr. Collins. The patient made a complete recovery and in the opinion of Dr. Collins, ovariotomy was a perfectly justifiable procedure. At the meeting of October 3, 1864, Dr. Collins reported the second operation for "ovarian dropsy" performed, also, by Dr. Burnham, of Lowell. Both ovaries were successfully removed; the tumors were multilocular and weighed approximately eighteen pounds.

Post Civil War Activities

During the Civil War, the Association was, for the most part, inactive. After the war, however, there was a larger attendance, and by 1870 as many as 25 members were present at one meeting. The population of Providence was approximately 69,000 and there were 144 doctors. But once again, as so often in the past, interest seems to have become dormant, so that in 1873-74, one member was three times appointed but did not appear to read his paper. Not even the President's famous clambake at Squantum was sufficient to entice the man who was expected to present the only paper. But for this deprivation there was, let us hope, some compensation, inasmuch as both Drs. C. W. Parsons and Virgil Hardon read original verses on the Rhode Island Clam to the cheerful satisfaction of their hearers who, no doubt, just then were more interested in humorous and stomachic than in more solid intellectual ailment.

That increase of appetite waits on mental effort is an ancient observation. Accordingly, it should not surprise us to learn that as early as 1856, Drs. Ely, Brown and Baker were appointed a committee "to ascertain the feeling of each individual member in relationship to having a collation or supper at the annual meeting and also to make the necessary inquiries as to a suitable place for the contemplated festivities." The committee made a favorable report, but for some inscrutable reason, the festivities got no farther than the stage of contemplation. After free and animated discussion, the As-



THOMAS POYNTON IVES

Mr. Ives, a member of a prominent Providence family, was interested in science, and he took a full course in medicine as a pupil of Dr. J. W. C. Ely. He gave valuable aid to the Providence Medical Association in its earlier years by providing a microscope and other scientific equipment. He was also a pioneer in the founding of the Rhode Island Hospital.

sociation voted with almost Stoic asceticism "to dispense with any such arrangement." And it was not until 1886, during the presidency of Dr. John W. Mitchell, that collations became and have continued to be, an important, if not always the most rewarding part of the Association's meetings.

In November, 1876, 25 members assembled to discuss the urgent problem of diphtheria which, during the two previous months, had caused 56 deaths, 32 of which were reported as diphtheria and 24 as membranous croup. Dr. Snow, the Superintendent of Health, and the majority of the members present held these conditions to be distinct diseases. In the early 80's, malaria appeared in Rhode Island; and in 1881, Dr. Keene presented a paper on the Reappearance of Intermittent Fever, reporting several cases which had originated in Barrington. For several years thereafter, malaria was the subject of frequent discussions.

In 1886, Providence had 125,000 inhabitants and about 225 doctors. The Association's membership was 86 with an average attendance of 28 at its meetings. Dr. Frank L. Day well described the meetings at this period as follows: "A report on recent progress in some branch of medicine was read at each meeting and usually a paper besides. These reports were discontinued only after several years, when they degenerated often into the reading of extracts from medical journals which ought to have been already familiar to every member. During the next fifteen years, the average attendance gradually increased. The meetings were sometimes quite interesting, but usually lacked unity. Papers were too long, rarely showing much original work or experience and rarely well discussed. An intimate friend of the reader was selected, who would highly commend the paper which covered the subject so thoroughly there 'was nothing to add.' Having thus delivered himself, he sat down, rarely venturing to criticize the reader's conclusions or even to amplify the facts. But few specimens were presented."

From its earliest period, the Association manifested its interest in public health and in matters other than the report of cases, the exhibition of specimens and the occasional reading of papers on medical subjects. The American Medical Association was founded in 1847, and at the meeting of March 5, 1849, it was voted to send Drs. L. W. Clifford, C. W. Parsons and J. W. C. Ely as delegates to the "National Medical Convention" which was to be held in Boston on the first Tuesday in May, 1849. At the meeting of May 7, 1849, the delegates to the convention made a verbal report. In the years which followed, delegates continued to be sent to the annual meetings of the American Medical Association. In the minutes of the annual meeting of March 3, 1851, there is a rather unusual entry. On motion of Dr. Mauran it was voted that "delegates accepting the appointment to the American Medical Association forfeit the sum of $5.00 in case of failure in attendance at the Association." After this salutary warning, Dr. E. P. LeProhon was appointed a delegate to the American Medical Association, which appointment he accepted.

Public Health Programs

At the meeting of January 9, 1865, the ire of the Association was aroused by the early closing of drug stores in the City. A committee composed of Drs. Collins, Ely and Snow was appointed to draw up resolutions which were unanimously adopted and ordered to be printed in the *Providence Daily Journal*. The resolutions declared that whereas it had come to the knowledge of the Association that a combination had been entered into by the apothecaries of the City to close their shops at 8 o'clock p. m., it was therefore resolved that "We have long witnessed with regret the inconvenience and difficulty to which our citizens have been subjected in obtaining medicines during the night and on Sundays; that public necessity requires that one or more shops shall be established in the City where medicines can be procured and prescriptions compounded by a thoroughly competent person at all hours of the day and night and on all days of the week; that we will give our influence and support to any competent apothecary who will keep his shop open and dispense medicine in accordance with these resolutions." Immediately after the passing of these resolutions, Dr. Collins moved that the thanks of the Association be extended to Mr. W. B. Blanding — one of the apothecaries —

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RHODE ISLAND HOSPITAL
Established in 1865

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for his courtesy in exhibiting a large and rare collection of surgical and obstetrical instruments.

For those whose sensibilities are sometimes shocked by the unkempt condition of our streets, it may be of interest to report that in 1865 our citizens were confronted by a worse evil. At the meeting of May 1, 1865, Dr. Snow read a paper on the influence on the general health of the keeping of hogs in connection with horse stables. After a thorough discussion of the paper, it was unanimously resolved that the keeping of hogs in the compact portions of any city is a nuisance which is dangerous to the public health and should never be permitted. That the keeping of hogs in connection with horse stables is especially dangerous to the public health on account of the diseased food which is raised to be eaten by our citizens; that as physicians, "we fully believe that it is impossible to keep hogs as they are usually kept about stables in this City, without their becoming diseased and unfit for food."

The plague of quacks seems to have been particularly troublesome in the early days of the Association. In 1877, Dr. Anita E. Tyng called attention to the prevalence of quackery and to the Medical Bill adopted in California which granted certificates only after examination to those not holding diplomas from approved medical schools. Dr. S. S. Keene spoke strongly in favor of a similar bill in Rhode Island; but others, especially Dr. Oliver C. Wiggin, opposed it. They argued that it was impracticable here because the press would object to it on account of the loss it would suffer from the advertisements of the quack doctors. Therefore, the vote of the Providence Medical Association was recorded as being opposed to the placing of restrictions on the practice of medicine.

Other matters with which the Association concerned itself in its first half-century were, in brief, the following: In 1855, a committee was appointed to confer with the public authorities as to the taking of a census, especially with respect of the information to be obtained for the general cause of science; in December, 1876, a committee was appointed to confer with the school committee concerning school hygiene; in 1884, extension of the sewer system was advocated; in 1894, it was voted to prepare for circulation among the legislators a pamphlet urging defeat of the antivaccination bill; in March, 1902, it was voted to endorse vaccination; in 1894, our Senators were urged to vote against a Senate bill for reduction of the Medical Corps of the U. S. Army; in April, 1898, it was voted to urge the reservation of Exchange Place for public use; in January, 1900, the Association went on record as favoring interstate reciprocity in medical registration.



ST. JOSEPH'S HOSPITAL
Established in 1892

Era of Specialization Begins

The second half century of the Providence Medical Association began auspiciously under the Presidency of Dr. Herbert Terry. The membership was 145 and the average attendance at meetings was between 30 and 40 during the next decade. In 1900 there were 309 doctors in Providence or one to 568 of the 175,000 population.

Up to this time, the majority of the membership were engaged in the general practice of medicine. Only a few physicians attempted to practice any specialty. Dr. Horace G. Miller had for some time been devoting his attention to conditions of the eye and Dr. George W. Porter was beginning the practice of gynecology in the little hut in back of the Rhode Island Hospital which had been built for him by some of his loyal patients and friends. Dr. John W. Keefe had already begun to practice surgery as a specialty. In addition to the Rhode Island Hospital, St. Joseph's Hospital had been opened in 1893 and the Providence Lying-In Hospital, established in 1887, was located in a wooden house on State Street. The age of specialization was beginning and during the next few years, nose and throat surgery was introduced by Dr. Frank B. Sprague, orthopedic surgery by Dr. Frank E. Peckham and Dr. John C. Pegram, Jr., neurology by Dr. Eugene Kingman, and dermatology by Dr. James R. Morgan.

As has been stated previously in this history, the early meetings were devoted to organization and the fixing of a fee table. Following these activities the desire for scientific advancement was expressed by case reports and the demonstration of pathological specimens. Instruments and laboratory procedures were exhibited. The next step was the reading of articles from medical journals for which the Association already had begun to subscribe. It is interesting to note that it has been the consistent policy of the Association from the very beginning to provide current medical journals for the use of

its members. These were kept at first in the rooms of the Franklin Society, 54 North Main Street, Providence. About 1900 the Association accepted the invitation of the Providence Public Library to house its books and medical journals on the top floor of the library building. Here they remained until 1912 when the medical society building with its excellent facilities for storage of books and display of medical journals was opened. As the scientific spirit in the profession advanced, members preferred to record their own experiences by reading original papers and presenting case reports. These papers were often illustrated by drawings and later by lantern slides. Specimens removed at operation or autopsy were also shown.

The Journal Is Started

Scientific papers wee first published in the *Atlantic Medical Weekly*. In 1899 the need for a local medical journal had become so urgent that the PROVIDENCE MEDICAL JOURNAL was established under the editorship of Dr. George D. Hersey. The Journal at once became popular and provided a vehicle for papers read by local physicians at various society meetings and also offered a medium for news of hospitals, district societies and small medical clubs. Each issue of the Journal was eagerly read, partly because of the incisive and stimulating editorials written by Dr. Rogers. The PROVIDENCE MEDICAL JOURNAL was published bimonthly until 1917 when it was purchased by the Rhode Island Medical Society and issued monthly thereafter. The change of ownership and dates of publication were made largely to secure advertising advantages which could be obtained by affiliation with the Advertising Bureau of the American Medical Association. This advertising was available to journals published by a state medical society but not when the journal was owned by a district medical society. By this change of name and ownership, the sphere of usefulness of the Journal was greatly enlarged.

In general the Association remained solvent. Occasionally at the annual meeting, the treasurer would report a deficit and some member would arise to reprove the Association for living beyond its income. For many years, the annual tax remained at $4.00, and only in comparatively recent years was it raised to its present figure.

As new procedures were developed they were exhibited before the Association. One of the earliest demonstrations was the technique of the Widal test. The discovery of the x-ray, which was first demonstrated to the association in 1896, seemed almost a miracle in those days and at nearly every meeting for several years following this date, x-ray plates of interesting or instructive conditions were exhibited. Many methods of treatment or advances in scientific technique were reported in the early years, only to be forgotten and revived as entirely new procedures. As an example, as early as 1901, it was reported that professional anesthetists were being employed in New York and also that spinal anesthesia ws used at that time. Twelve deaths resulting from spinal anesthesia were reported from the maternity ward of the New York City Hospital. It is possible that this high mortality had some influence in causing this method to be frowned upon, only to be revived in recent years. District Nursing was brought to the attention of the Association in 1900, and interstate reciprocity in medical legislation was approved the same year.

The membership of the Association continued to increase slowly, keeping pace with the growth

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GEORGE D. HERSEY, M.D.
First Editor of the *Providence Medical Journal.*



FREDERIC T. ROGERS, M.D.
First Business Manager of the
Providence Medical Journal.

of the city so that 18 new members were elected in 1900. More use was made of the Reading Room and there was an increase in the number of journals received and exchanged. The PROVIDENCE MEDICAL JOURNAL had maintained its good reputation. Papers read before the Association were contributed largely by the local membership but several times each year, papers would be presented by eminent members of the profession from Boston, New York and elsewhere.

Public Health Advances

Public health measures were introduced from time to time and Dr. Charles V. Chapin was largely instrumental in proposing methods for the restriction of tuberculosis, for the improvement of the milk supply and for the treatment of contagious diseases in which he had already gained a world-wide reputation. In 1903, Dr. Chapin announced his intention to resign as Superintendent of Health of the City of Providence. Resolutions were adopted by the Association expressing regret at his resignation and the City Council was petitioned not to accept Dr. Chapin's resignation. In view of the widespread desire that this capable medical officer should continue at his post, Dr. Chapin withdrew his resignation and continued as a useful city official for 23 years.

Some interest in medical history was manifested and papers were read on early medicine in Rhode Island, including a history of small pox. The business side of the profession was not neglected and an occasional paper on this subject served to stimulate interest in a revision of the fee table. New by-laws were adopted in 1904 but the necessity for amendments caused this subject to be before the Association for several years to come.

Appendicitis was first discussed before the Association in 1888 but a poll of the membership in 1904 found medical opinion equally divided between operative and conservative treatment.

The medical profession throughout the country was showing its interest in legislation to improve the public health, and a bill to regulate the manufacture and sale of patent medicines received the hearty endorsement of the Association. Members were urged to contact their Senators in Congress asking support for the Pure Food and Drug Act.

At the October, 1904, meeting, as an indication of increased interest in scientific work, a report was made of 9 section meetings at the meeting of the American Medical Association held a short time previously at Atlantic City. Each of nine members reported on the papers read before his respective section.

In 1905 papers were presented by eight members on the Venereal Peril. A resolution was introduced, affirming that it was the duty of Health Boards and Health Officers to educate the laity as well as the medical profession, as to the cause and danger of these diseases. A resolution was introduced to substitute a Reformatory for women in place of the Women's Department of the House of Correction and Workhouse, with two women on the Board of State Charities and Correction and women Superintendents at the Reformatory and Oaklawn School. Further interest in public health was shown by the resolution presented by the Association to the General Assembly urging the establishment of a State Sanatorium for Tuberculosis. This suggestion aroused the interest of the public and authority was given by the General Assembly for the establishment of a Sanatorium at Wallum Lake. This institution has proved a valuable addition to our facilities for the treatment of this disease. A few months later, the Association approved a project of the Rhode Island Chapter of Architects to secure better plumbing laws for the City.

At this time, the re-organization plan of the American Medical Association which had been adopted the previous year began to function. Delegates had been elected to the House of Delegates of the Rhode Island Medical Society and a Delegate appointed to the House of Delegates of the American Medical Association.

For many years, the Association had met in the rooms of the Franklin Society at 54 North Main Street, Providence. The rooms were unsuitable for the meetings because the attendance had grown with the increased size of the Association and the widespread interest in their proceedings. Accordingly, when an invitation was received from Brown University inviting the Providence Medical Association to hold its meetings in Rhode Island Hall, the invitation was gratefully accepted. Fortunately a recent fire in the Anatomical Laboratory had necessitated alterations so that a much more suitable meeting place was obtained. An epidiascope had recently been installed and was an excellent device for demonstrating x-ray plates, postmortem specimens and charts. The Association signified its appreciation of the courtesy of Brown University in providing them a suitable meeting place, by presenting to the Anatomical Department oil immersion lenses for use with the epidiascope.

In 1906 a resolution was introduced urging the establishment of a State School for the care and education of feeble-minded children. This resulted later in the school at Exeter which has proved its usefulness many times over.

Testimonial to Dr. Ely

On April 27, 1906, occurred one of the most noteworthy gatherings in the annals of Rhode Island medicine. Dr. J. W. C. Ely was given a testimonial dinner by the local medical profession

on his completion of 60 years in the practice of medicine. Only a few weeks before at a meeting of the Association, Dr. Ely had given a very interesting account of the treatment of pneumonia when he began practice and the changes that had occurred since it had been recognized as a self-limited disease. At the dinner, letters were read from various members of the medical profession, hospital officials, former classmates and friends. Professor William Osler sent a delightful letter from Oxford and Dr. Frederick C. Shattuck of Boston, an old friend of Dr. Ely, spoke in ardent praise of his accomplishments over these many years. Within a few days, this notable physician died, and the next meeting was adjourned out of respect to his memory.

About this time an epidemic of rabies appeared in the community and methods for the control of this disease in human beings were instituted and carried on for a number of years until the danger of transmision had passed.

It began to be appreciated that more stringent marriage laws should be enacted in the case of the mentally unfit. This suggestion has been broadened and enacted into law so that transmission of venereal disease is practically prevented by pre-marital blood tests. Further legislation was advocated in support of the Optometry bill to protect the public, by requiring that persons professing to advise the public in connection with changing vision, should be required to show a sufficient knowledge of medicine and surgery before a board of medical registration. From time to time various measures were approved such as the Owen bill providing for the establishment by Congress of a Secretary of Health in the Cabinet. The printing of the Constitution and By-laws was authorized at this time.

A study of the papers presented before the Association during this period shows a wide range of interest. Almost every specialty was represented together with papers and informal talks on subjects related to the medical art. As an example of this widely diffused interest, a resolution was presented asking for the appointment of a committee from the Association to confer with a committee of the Rhode Island Bar Association and the Rhode Island Medical Society to advise on commitment of the insane.

Medical Library Built

For many years, it had been the ambition of the Rhode Island Medical Society to have a home of its own and a Building Fund had been established. The movement was stimulated by the request of the Providence Public Library that at an early date the room used for medical books and journals should be vacated. The March, 1911, issue of the Providence Medical Journal contained an illustration of the projected medical library building together with architectural plans. The corner stone was laid with fitting ceremonies on June 1, 1911, in the presence of State and City Officials, dignitaries of the Church and representatives of local libraries. Addresses were given by distinguished visitors on the value and function of a medical library. This evidence of interest on the part of the medical profession was received with enthusiasm in a city noted for its many special libraries. In June, 1912, the Rhode Island Medical Society held its annual meeting in the building which had been recently completed. In October, 1912, the Providence Medical Association convened for the first time in the Rhode Island Medical Society building, where the meetings continue to be held. In 1912 the population had risen to over 224,000. There were 409 physicians, or 1:548 of the population. 1912 seemed an opportune year to change the date of the annual meeting from March to January to coincide with the calendar year.

About this time it was proposed to hold a mid-winter social and an appropriation was made for this project. At a subsequent meeting this suggestion for a social evening was rejected and to date has never been revived. In recent years, a golf tournament with prizes, followed by a dinner held each September, has supplied the need for a social gathering.

The Association continued to request the General Assembly to appropriate loans for construction of new buildings at the State Hospital, the State Sanatorium, the Rhode Island School for Feeble Minded, the State Home and School and the Rhode Island Institute for the Deaf. The action of the Housewive's League in their efforts to improve the milk supply of the City of Providence was approved and the support of the medical profession was tendered to this worthy object. The inauguration of a medical defense fund was requested and a delegate from the Association was appointed to confer with a committee of the Rhode Island Medical Society in this matter. The subject was ultimately settled by the recommendation and selection of an insurance company to defend the members of the Association in cases where medical defense was necessary. The daily papers were requested to publish the names of poisons used in suicide together with information concerning the fatal dose of these poisons and the proper antidotes to be administered.

The attendance at meetings had gradually risen because of the greater interest in the Association and because of the increase in the number of phsicians practicing in this community. A movement had been launched for the passage of a Workmen's Compensation Act in the state to provide for ade-

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quate medical care and compensation of injured workmen and bills were introduced into the General Assembly urging the passage of such legislation. A committee was appointed and for several years following, this subject was the basis of much discussion and argument. For many months an editorial on the subject appeared in each issue of the PROVIDENCE MEDICAL JOURNAL and its successor the Rhode Island Medical Journal. Amendments to the bill were introduced, always with the object of protection of the workman in his rights and benefits. Heated arguments took place both in committee meetings and in open sessions of the Association.

The Friedman Story

To one who joined the association in 1912 the quiet minutes of the meetings during the first World war make one realize the force of a famous Frenchman's remark: "History never embraces more than a small part of reality."

Indeed one who attended the earliest of these meetings has this brought home to him as he reads the record of secretary Charles O. Cooke for February, 1914:

"The Tuberculosis Problem was presented by Dr. William G. Dwinell. He presented many patients showing the results of the Freedman Treatment." In March we find "a communication was read from Dr. William G. Dwinell relative to action by the Standing Committee in refusing publication of his paper. No action was taken on the communication".

It is probable that none but the older doctors has the slightest knowledge of the story hidden behind these uninteresting sentences. At that time there was a hopeful feeling that tuberculin might be of great value in the treatment of tuberculosis. A German named Friedman came to the U.S.A. with preliminary heralding of the miraculous cures that he was achieving with a serum obtained from turtles afflicted with this disease. The American public received him enthusiastically. Only the hidebound, non-progressive reactionary medical profession had any doubts but most of them were extremely skeptical. Our newspapers were more than shocked and grieved; they were disgusted with us.

A plan was formed to have Friedman Institutes throughout the country where treatments could be given. Only one was really started and that one was opened by Dr. Dwinell on Reservoir Avenue. A few Providence doctors supported him but the rest were skeptical.

The aforesaid few, however, were possessed of almost religious fanaticism; the meetings were animated and highly controversial. The report of the Association's secretary is, however, a masterpiece of restraint.

For a short time the Institute did a thriving business; but today scarcely a person under fifty years of age remembers Friedman's Turtle Serum.

The attendance at meetings had begun to approach 100 and the financial condition was satisfactory. The PROVIDENCE MEDICAL JOURNAL had sufficient funds and had obtained the approval of the profession throughout the state.

The largest attendance in the history of the Association was noted at a special meeting on April 20, 1914, when Dr. Charles H. Mayo of Rochester, Minnesota, read a paper on "The Vascular Transmission of Disease." Members of the other District Societies had been invited and an audience of 250 members and guests taxed the capacity of the auditorium. Dr. Mayo told his audience that evening that chronic gall bladders, chronic appendicitis, ulcers of the stomach and rheumatoid arthritis all had their origin in foci of infection in other parts of the body. He cited the work of Rosenow who made cultures from diseased gall bladders and when the cultures were injected into dogs these immediately got cholecystitis and even cholelithiasis. Ulcers of the stomach however were treated by gastroenterostomy, not by teeth extraction. Seven years later a group of professors from the Harvard Dental School expressed doubt as to the role of focal infections and questioned Rosenow's work.

Dr. Mayo was of opinion that cancer developed where acid conditions existed in the body, as the mouth, stomach, colon and urinary bladder. He even found that breast cancer arose in an acid environment. Of these views of Dr. Mayo we are skeptical today, but whatever may be his worth as a medical philosopher he was an illustrious surgeon.

The smallest attendance during this period occurred in October, 1918, when only 13 members were present. This was the lowest attendance since the early days of the Association and was attributed to the fact that World War I was then at its height. Many physicians were in service and those at home were engaged in a battle with a severe epidemic of influenza which raged throughout the entire world.

Before the entry of the United States into World War I, several members had gone to Europe with the first Harvard Unit. On their return, the medical work at base hospitals in France was described to the great interest of those present. Food Conservation became a live issue during World War I and the campaign of the Housewive's League received endorsement and the offer of cooperation.

At each annual meeting, the retiring President delivered an address, and usually suggested some innovation which would improve the conduct of meetings and make for a wider interest in the work of the Association. At the annual meeting in

January, 1918, the President's annual address was read by another member. For the first time in the history of this Association a President, Dr. Frank E. Burdick, had died in office only a few days before the expiration of his term of service.

In December, 1917, occurred the Halifax disaster. The widespread destruction and the injuries sustained by the population of that city had shocked the entire world. A relief party composed of volunteer physicians, some in uniform and awaiting a call to service, together with nurses, was dispatched to Halifax and did valuable work in aiding the local authorities to care for the large number of injured.

A committee had been appointed to confer with a committee of the General Assembly for a hearing on the bill to revise the health laws of the state. This request was denied by the Chairman of the Legislative Committee much to the disappointment of the medical profession. The hospitals were beginning to feel the financial strain and already the Rhode Island Hospital had made efforts to secure appropriations from towns outside of Providence for the care of those unable to pay for hospital care.

The complication of pneumonia following the epidemic of influenza at the base hospital in Queenstown, staffed by the Rhode Island Hospital Unit, was described by one of the staff and an interesting paper on "The Cruise of the Charles Whittemore" — the mystery ship — was delivered by Dr. G. W. VanBenschoten. At the same time the epidemic at military camps in this country was discussed by members who had served at these base hospitals.

In 1921 the population was 237,600; there were 441 physicians, or 1:538 of the inhabitants. The membership had now passed the 300 mark and the treasurer reported a substantial balance in the treasury. It was the custom each year to appropriate $300.00 for the use of the medical library and $175.00 for the subscription and binding of medical journals.

The New England Surgical Society held its meeting in Providence in October, 1920. There was a large attendance of local surgeons and interesting clinics and papers were presented.

Federal Health Programs Start

On October 3, 1921, the attention of the Association was first drawn to what seemed to be a new menace to medicine, when Dr. John J. O'Meara read a paper on Social Welfare Activities of Interest to Physicians. He called attention to recent legislation concerning venereal diseases, birth registration and workmen's compensation acts and spoke also about the Shepherd-Towner and Smith-Towner bills. The gist of his paper was a warning against the increasing tendency to federalization in matters of health. In November of the same year, Dr. Henry Christian discussed the relationship between hypertension, myocarditis and nephritis, and was followed, in December, by Dr. Douglas Quick, of New York City, who presented a paper on the response of various types of cancer to radium. The best results, he said, were derived from the triple alliance of radium, x-rays and surgery. During the subsequent discussion, Dr. Greenough, of Boston, characterized radium as the greatest contribution to the surgery of cancer since anesthesia and asepsis, but insisted that radium was an aid to, not a competitor of these.

Dr. Isaac Gerber's contribution to the meeting was a paper on Some Aspects of the New Intensive X-ray Treatment. The Presidential address of Dr. Frank T. Fulton dealt with the endocrine glands. Dr. Fulton spoke of existing knowledge concerning the different members of this group and of the conflicting evidence supplied by various observers as to the results of treatment; he deprecated the ill-judged enthusiasm, not based on solid physiological grounds, of many clinicians.

From 1922 to 1932, the meetings of the Association were devoted to the quiet, more or less routine presentation of informative papers on such subjects as were then engaging the attention of the profession; for example, arteriosclerosis, cancer of the stomach, oral sepsis, anterior poliomyelitis, post-operative pulmonary sequelae, tuberculous glands of the neck, intussusception in adults, the diagnosis of pulmonary tuberculosis, the probleems of diabetes, hypertension, peptic ulcer, recent changes in mental medicine, diphtheria immunization, radium therapy of cancer, placenta praevia, blood transfusion, the treatment of pneumonia with serum, the treatment of pernicious anemia with liver and the biochemistry of blood sugar.

Medical Milk Commission

At the meeting of November 2, 1925, Dr. Henry Utter suggested and it was voted that the President be empowered to appoint a committee of three to take up the matter of the duties and the personnel of the Medical Milk Commission. At the following monthly meeting, the committee defined the duties of the Milk Commission as follows: To receive petitions for the production of certified milk; to designate a sanitary inspector, a veterinary for cows, a physician to examine employees of the farm and an analyst to make bacterial counts and to determine the content of the various elements of the milk.

In his address as President of the Association, Dr. Henry J. Hoye, on January 2, 1928, reviewed

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the hospital situation in Providence with special reference to the care of chronic diseases. Dr. Hoye deplored the lack of proper accommodations for these patients and urged the establishment of a hospital for their reception. At the same meeting, Dr. Harvey Sanborn expressed his belief that the Association should endorse Dr. Hoye's address, especially that part of it having regard to the need for a psycopathic hospital. It was then voted that the Association extend to the City Hospital Commission its hearty endorsement of the plan for a psycopathic ward at the "City Hospital", and it was also voted that a committee be appointed to report on the need for a hospital in this community for chronic cases.

Executive Office Established

In view of the rapidly changing ideas regarding Social Legislation, the Association had already begun to appreciate its responsibility in Medical Care of the low-income group.

In his presidential address in 1937 Dr. William S. Streker suggested the advisability of a full time Executive Secretary for the Association. A Committee was appointed to propose a plan for reorganization of the Association and a recommendation whereby membership in the Providence Medical Association should automatically constitute membership in the Rhode Island Medical Society. Such dual membership is almost universal in most states in the Union, but due to misunderstanding as to the intention of this suggestion, it was not until 1943 that the unification was accepted.

As Social agencies multiplied and expanded their efforts, advice was sought from the medical profession and physicians were appointed to serve in an advisory capacity on the governing boards of the Providence District Nursing Association, the Bureau of the Handicapped, and other organizations. Committees were appointed to consider X-ray examination of industrial employees and food handlers, and examination of tuberculosis contacts and a follow-up of persons found suffering from pulmonary diseases.

The Committee on Reorganization reported amendments to the By-Laws by which the Standing Committee (to be known as the Executive Committee) would be enlarged to ten members. The Committee also recommended the employment of an Executive Secretary. Both amendments were adopted at the October, 1937, meeting and Mr. John E. Farrell was appointed Executive Secretary the following June. With this commitment to employ an Executive Secretary the Association took a step forward which has done more to increase the efficiency of its work than any previous legislation in its history. The Association has received country wide recognition for its sound ideas and advanced thinking along the lines of medical and social legislation. Resolutions were adopted suggesting amendments to the Pure Food and Drug Act regarding control of harmful drugs and diagnostic and therapeutic devices and cosmetics.

Scientific programs began to feature an occasional symposium and its more captivating variation — the panel discussion. Group hospitalization was the next subject of Committee investigation. The Publicity Committee — later to be known as the Committee on Public Relations — in keeping with the times, was proposing a radio program in addition to its press work and also recommended the publication of a monthly bulletin to deal principally with matters of economic and social significance. The problem of tuberculosis was perennial, and from time to time legislation was requested from the General Assembly regarding the reporting of suspected cases and better control of the disease. It was further recommended to have at least one paper each year by a guest speaker on this subject.

In February, 1939, a Committee was appointed to study the problem of Voluntary Health Insurance and allied matters. The General Assembly had passed an act to incorporate a nonprofit corporation for the operation of a group hospital service plan which later became popularly known as the Blue Cross. The Association was asked to endorse the Basic Science Law, then before the General Assembly, and in cooperation with the Rhode Island State Dental Society an act for strengthening and raising the standards of regulations for dentistry was recommended.

By 1939 the value of the Executive Secretary began to be more fully appreciated, and his influence in the community had enlarged so that he was authorized to accept an appointment on the Council of Social Agencies. He has also served as the accredited legislative agent of the Providence Medical Association in observing the activities of the General Assembly regarding health legislation and as the representative of this Association to the American Public Health Association. In numerous other capacities he has promoted the interest of the Providence Medical Association and increased its prestige in this community and throughout the country.

Public Policy Program

An outstanding report of the Committee on the study of the need and supply of medical care in the greater Providence area was completed by a group headed by Dr. Eske H. Windsberg. This study, published later in the Journal of the Amer-

ican Medical Association, reviewed existing facilities for medical care, free and part-pay care, and the need for medical care as reported by hospitals, physicians, dentists, health departments, and welfare and relief agencies, both public and private.

Committees were also appointed to study the problem of credit and collection for physicians and to increase the membership of the Rhode Island Medical Society. A vigorous resolution expressed the Association's opposition to the Wagner National Health Act. The Socio-medical activities of the Association at this time embraced every aspect of health and better living for the community. In April, 1940, the Association endorsed the educational campaign of the American Society for the Control of Cancer and the Women's Field Army of Rhode Island. As an evidence of its interest in the future generation of physicians, a prize of $50 was awarded for the best presentation in the House Officers' Case Report Contest.

A weekly radio program with a member of the Association presenting a fifteen minute talk on a medical or health subject provided a major contribution in public relations. Later, when the program had been adopted by the State Medical Society, a notable radio feature was introduced by the executive secretary, in 1941-42, whereby highlights in the news from the realms of medicine and public health were broadcast weekly. This program won the plaudits of the American Medical Association's bureau of health education.

A study of group health and accident insurance plans for the membership resulted in the decision to approve of no one plan, rather to provide educational material to advise the physician on how to read health and accident contracts to his own advantage. This Policy Digest, copyrighted by the Association in 1940, has won international attention and more than six thousand copies have been distributed on requests from physicians in every part of the United States and Canada, as well as in several other countries. Insurance authorities have rated this Digest as one of the finest summaries of insurance policy provisions ever published.

Second World War

World War II was over a year old and this country was already engaged in plans for Medical Preparedness, since it was inevitable that we should eventually become involved in the conflict. In October, 1940, Dr. Halsey De Wolf, Chairman of the State Board of Medical Preparedness, outlined the plans of organization of the State Committee and Major Lloyd C. Wilson explained the Selective Service system and the operation of local boards. This Committee later became known as the Procurement and Assignment Committee. Cooperation of the physicians was entirely voluntary in the beginning, but after the entry of the United States into the War the Committee on Medical Preparedness did an excellent job in enlisting all physicians eligible for service.

Members of the Association fought in every theater of conflict in the world, and many members were cited for their heroic and distinguished service in the defense of our country. Four members died while in service. They were Drs. Thomas A. Martin, Irving Blazar, Raymond Luft, and Milton Korb.

It is interesting to note the increased sense of responsibility evidenced by the profession toward those members enlisted in military service. In contrast with the custom in World War I his interests at home were safeguarded, and letters, gifts, and medical journals were forwarded regularly to his theatre of action. On his return from service he was enthusiastically welcomed home and assisted to rehabilitate himself in practice as far as is consistent with the limitations of human nature.

Postwar Progress

The Association's prize for the House Officers' Case Report Contest was awarded to Dr. Michael Di Maio for his essay on "Addison's Disease." At the October, 1941, meeting the subject of Vitamins was presented in an interesting panel discussion. The nervous and mental casualties of the previous war were stated to have cost the country one billion dollars and a plan for better screening of these cases at induction examinations was presented. A program of the Rhode Island Children's Heart Association was expanding and was shortly to take over the Crawford-Allen Hospital which up to this time had been occupied largely by orthopedic cases.

The June meeting had always conflicted with the annual meeting of the Rhode Island Medical Society, traditionally held the first week in June. In May, 1942, an amendment to the By-Laws was recommended and later adopted omitting the June meeting. The Association displayed a healthy growth. The membership had passed the 500 mark with an average attendance of over 150 at each meeting. The budget was large and increasing each year. The *Medical News,* a sprightly monthly magazine founded in 1940 at the initiative of the Executive Secretary, continued to function until July, 1943. At this time it was determined that the interests of the Rhode Island Medical Society and the Providence Medical Association would be better served to the mutual advantage of both groups by a combination of their activities. Accordingly a plan was effected whereby the executive office was consolidated under the joint management and operation of the Rhode Island Medical Society and the Providence Med-

continued on next page

ical Association. This reciprocal agreement has proved universally satisfactory. The *Medical News* ceased publication and the RHODE ISLAND MEDICAL JOURNAL assumed its functions.

The February, 1943, meeting of the Association was held in conjunction with the Rhode Island Medical Society as had been the custom for the past few years. This cooperation of interest has received the approval of the medical profession and has been beneficial to organized medicine as a whole. Dr. Herman C. Pitts, Chairman of the Public Health Committee of the Rhode Island Medical Society, presented a comprehensive review of the social aspects of medical practice in this country and abroad. He also discussed the Cash Sickness Compensation Act, which was soon to become a law in Rhode Island, and was to provide many a headache for the local profession. The plan for prepaid medical care in Massachusetts was presented by Dr. James C. McCann of Worcester. The meeting was honored by the presence of Dr. James E. Paullin, President-Elect of the American Medical Association, who was pleasantly remembered by many of the local profession from his Interne days at the Rhode Island Hospital. Dr. Paullin reviewed the work of the profession in the present crisis and urged continued support of the war-time program to render the best possible care to the civilian population as well as to the men in the armed forces.

The subject of emergency cases at night and the traditional "Wednesday off" was proving embarrassing to the physicians and a topic of criticism by the public. The Physicians Exchange reported that it was unable to handle this emergency and the problem is still to be solved.

At the November, 1943, meeting an amendment to the By-Laws was proposed providing for dual membership in the Rhode Island Medical Society and the Providence Medical Association. At the same meeting slides in color taken by members of the 48th (Rhode Island Hospital) Unit in India were shown.

At this time the subject of practice of medicine by hospitals was discussed with particular reference to the status of roentgenologists and anesthetists. The Association approved the position taken by the House of Delegates of the American Medical Association that these services should be considered as medical and not a part of the hospital care as covered by Blue Cross contracts.

Under the presidency of Dr. B. Earl Clarke an active program for the study and improvement of air pollution in Providence, largely due to smoke, was introduced. As the result of the initiative shown by the Association in this problem a citizens committee was organized and within the year a new city ordinance had been enacted and a division of smoke inspection established within the city engineers department. The pollution of the waters of the city and state drew the censure of the Association in 1946.

In November, 1945, the Rhode Island State Dental Society joined with the Providence Medical Association in a combined program. Better cooperation between these two groups and with the Rhode Island Medical Society was urged, and a survey of the present situation was recommended to improve the Medical-dental relationship.

At the combined meeting of the Rhode Island Medical Society and the Providence Medical Association held in February, 1947, a Committee was appointed to initiate plans regarding the Association's Centennial to be celebrated in January, 1948, and particularly to consider the question of the history of the Association in connection with this observance.

Physicians returning from military service were exempted from dues for the first six months after their resumption of practice. The activities of the Association now required the appointment of twelve special standing committees. Provision was made for the election of Associate members and for Internes and Residents in local approved hospitals.

In April, 1946, a panel discussion was given by members who had served in various theatres of war including England, the European Continent, India and the Pacific area. The importance of home nursing was stressed in view of the shortage of doctors, nurses and hospital beds. Physicians were urged to recommend Red Cross courses in home nursing to their patients. The physicians of Bristol County had recently organized as a District Society and thereby removed from the jurisdiction of the Providence Medical Association. As part of the program of the American Medical Association to restore the General Practitioner to his rightful place in the public esteem, it was voted to refer to the Rhode Island Medical Society the question of forming local chapters of the American Academy of General Practice.

The Surgical plan of the Rhode Island Medical Society was endorsed and members of the Association were urged to demonstrate their approval of this program by enrolling promptly as participating physicians. It was later reported that each of the district Medical Societies in the State had taken the same action.

The Committee on Legislation this year initiated the movement for the improvement of sanitation in eating establishments in the City. A model ordinance was submitted to the City Council, and a program outlined for action to assist in the educa-

continued on page 33

PIONEERS OF THE PROVIDENCE MEDICAL ASSOCIATION



J. W. C. Ely, M.D.
First Secretary



George L. Collins, Sr., M.D.
Outstanding surgeon of his day; a vice president of the American Medical Association, 1871 and 1876



Lewis L. Miller, M.D.
Vice President in 1848

Lewis W. Clifford, M.D.
First Treasurer



Henry W. Rivers, M.D.
(At whose office the first meeting was held)



MINUTES OF FIRST MEETINGS OF THE PROVIDENCE MEDICAL ASSOCIATION, 1848

At a meeting of the physicians of Providence, held at the office of Dr. H. W. Rivers, January 31st, 1848, it was voted a city Medical Society or Association should be formed, for the mutual benefit of its members.

Dr. S. Augustus Arnold was appointed Chairman—and Dr. J. W. C. Ely, Secretary Pro Tem.

Drs. G. L. Collins, H. W. Rivers and S. A. Arnold were appointed a committee to draft a Constitution and By-Laws, for such a Society or Association.

The meeting was adjourned to the office of Dr. J. Mauran — Saturday evening, February 5, 7½ p.m.

According to adjournment the physicians met at the office of Dr. J. Mauran to hear and act upon the report of Drs. Collins, Rivers and Arnold.

The report of Constitution and By-Laws was read and accepted — with some amendments it was adopted as the Constitution and By-Laws of the Association.

The same Committee were continued and instructed to draw up a Fee Table, and what other By-Laws might be thought necessary and to report at the next meeting.

The meeting was adjourned to Monday evening, February 14th 7½ o'clock—and to such place as the Secretary could procure.

The Association met at the Franklin Society rooms — according to adjournment, to hear and act upon the report of the Committee on a Fee Table. It was read and accepted. With some amendments it was adopted by those present, as a part of the By-Laws.—Drs. Mauran, Arnold, Capron, Utley, Collins, Haszard, N. Miller, Pratt and Angell. — The Committee were discharged.

Drs. Mauran, Arnold, Capron and Miller were appointed a Committee to present the Constitution and By-Laws to the physicians of the city for their signatures.

The meeting was adjourned to the annual meeting — March 6th 7½ p.m. to be held at the Franklin Society rooms.

J. W. C. ELY, Secretary Pro Tem

* * * * * * *

Providence March 6th, 1848

Dr. Arnold in the Chair.

Meeting called to order by the Chairman. Proceedings of the last meeting read — Constitution and By-Laws were also read.

Drs. Mauran, Capron and Ely were appointed a Committee to nominate officers for the ensuing year.

This committee reported the names of the following gentlemen — who were unanimously elected

Dr. S. Augustus Arnold	President
Dr. Lewis L. Miller	Vice President
Dr. Lewis W. Clifford	Treasurer
Dr. J. W. C. Ely	Secretary
Dr. Henry W. Rivers Dr. Charles W. Parsons Dr. George L. Collins Dr. Edmund V. Hathaway Dr. Henry P. Pratt	(Standing Committee)

The following amendment of Sec. 6 Article VI of the By-Laws was offered by Dr. C. W. Parsons and referred to the Standing Committee. "In any case when the physician believes his patients cannot afford to pay the regular fees, without distressing themselves or their families, and yet are able to make some remuneration, the physician may, at his discretion deduct from the charge .....".

The following amendment of Article III of the Constitution was proposed by Dr. Mauran. "The members shall be regular practitioners of medicine or surgery in the city of Providence and members, or those who have made application to become members of the Rhode Island Medical Society." It was referred to the Standing Committee.

The meeting was adjourned to Monday evening — April 3d 7½ p.m. — at the Franklin Society rooms.

J. W. C. ELY, Secretary

* * * * * * * *

Providence April 3d 1848

President in the Chair.

Meeting called to order — Proceedings of last meeting read.

The Standing Committee reported in favor of the proposed amendment of Section 6 Article VI of the By-Laws and requested more time to consider the proposed amendment of Article III of the Constitution.

The proposed amendment of Section 6 Article VI of By-Laws was adopted by the Association.

The following amendment to Section 1 Article VI — of fees, was proposed by Dr. Armington —

"For advice at physician's house, according to the importance of the case and time occupied 50 cents to $5.00."

It was referred to the Standing Committee.

The meeting was adjourned to Monday evening — May 1st 7½ p.m. at the Franklin Society rooms.

J. W. C. ELY, Secretary

PROVIDENCE MEDICAL ASSOCIATION
1848-1948

concluded from page 30

tion of food handlers and in the enforcement of the sanitary code.

We Are Healthy and Strong

The second half century of the Association's history has demonstrated that the principles enumerated by the Founders were sound and enduring. We who are their heirs and successors have vigorously defended their convictions. With each advance in scientific knowledge we have at the same time recognized the changing concepts of the physician's relations to the state and to his patients. To safeguard the public health has always been our first intention and will continue to be our purpose as we enter our second century of service to the community. We are healthy and strong. May we never forget our mission to cure sometimes, to to relieve often, to comfort always.

STATE OF RHODE ISLAND, &c.
IN GENERAL ASSEMBLY,

May session, A.D., 1887.

AN ACT

to incorporate the Providence Medical Association.

It is enacted by the General Assembly as follows:

SECTION 1. J. W. C. Ely, Charles W. Parsons, Chace Wiggin, Edwin M. Snow, George P. Baker, John W. Mitchell and all other present members of the Providence Medical Association their associates and successors are hereby made a corporation by the name of The Providence Medical Association for the advancement of sound medical science and the promotion of the character, interests and honor of the medical fraternity with all the powers and privileges, and subject to all the duties and liabilities set forth in Chapter 152 of the Public Statutes, and in any acts in amendment thereof or in addition thereto.

Sec. 2. Said corporation may take, hold, transmit and convey real and personal estate to an amount not exceeding twenty thousand dollars.

Sec. 3. This act shall take effect on and after its passage.

State of Rhode Island and
Providence Plantations

Office of the Secretary of State
Providence, June 24th A.D. 1887

I certify the foregoing to be a true copy of an act passed by the General Assembly of said State on the fifteenth day of June A.D. 1887. In testimony whereof I have hereunto set my hand and affixed the seal of the State aforesaid the date first above written.

Edwin O. McGuinness
Secretary of State

THE PROVIDENCE CITY HEALTH DEPARTMENT, 1856 — 1948

JOSEPH SMITH, M.D.
First Deputy Superintendent, Providence Health Department

IN JANUARY 1848 the physicians of the City of Providence founded the Providence Medical Association. The City of Providence was only 15 years old at the time.

Of course, Providence was founded in 1636 but it took the riots of September 1832 to convince the populace that they should organize a municipal form of government.

In 1849, and again in 1854, cholera visited this young city in epidemic form and killed off over 150 at each visit. Something had to be done.

Fortunately, Dr. Edwin M. Snow, the Secretary of the young medical Association, was elected to the City Council in 1855 and used this sounding board to arouse the populace as the riots in 1832 aroused them. Dr. Snow was a real scientist. He planned wisely. The first move was to get the facts. At the May 1855 session, a special act creating the City Registrar's Office was passed and Dr. Snow was elected by the Board of Aldermen the first City Registrar, in July, 1855.

In December 1855, the City Council passed the following ordinance requiring the City Registrar annually, "To prepare and present to the City Council, a statement of the number of births, of marriages solemnized and of deaths which occurred in the City during the year ending with the thirty-first day of December, next preceding, with such other information and suggestions in relation thereto as he may deem useful for the promotion of the *Public Health* and other interests of the City."

In his first report, Dr. Snow also included tables of deaths for the years 1840 to 1854 inclusive, which were prepared by Dr. George L. Collins with the cooperation of Dr. Ely. These names all have a familiar ring to those who have read the early minutes of the Association.

Following the publication of this first report and in accordance with the recommendations of the Association and Dr. Snow, legislation was obtained from the State, to setup the City Health Department in July 1856, with Dr. Snow as the first Superintendent of Health. The first annual report of the Superintendent of Health was published on July 14, 1857, for the year ending July 1, 1857.

This report is well written and, except for the references to impure air being the cause of the excess of mortality in cities, is as modern in thought as any public health publication of today. The duties of a health officer, the qualifications of a health officer and the relationship of health and environment are all clearly stated in this report.

Dr. Snow continued as Health Officer until January 1884 and as City Registrar until his death, December 22, 1888. He was a past president of the Association and also of the American Public Health Association. He was a real pioneer and a recognized authority in the field of Public Health in his day.

While we in Providence have always loudly proclaimed that politics never have influenced the conduct of the Health Department, it was politics that ended Dr. Snow's tenure of office as Health Officer. In 1883 one of our City Fathers had a child sick with scarlet fever. As a result Dr. Snow placarded the home. This City Father felt that his position was such that exception should be made in his case, and when Dr. Snow refused, he threatened to have him removed. He took his fight to the party bosses and lacked one vote to supplant Dr. Snow with his own candidate. However, in his search for votes he found one man who stated that if Dr. Snow was to go, he had his own candidate, a young man just out of medical school, Dr. Charles V. Chapin.

Dr. Chapin was recuperating from a broken leg received when thrown from his horse in the Carolinas where he had gone to start his practice. The City Father, with the removal of Dr. Snow uppermost in his mind, immediately proposed Dr. Chapin for the position and Dr. Chapin's name was entered on the ballot in place of Dr. Snow. He was elected Health Officer without knowledge of the facts in the matter.

The facts, however, soon became known and at the January meeting sufficient public interest was aroused to force the Board of Aldermen to reelect Dr. Snow as City Registrar.

In January 1884, Dr. Chapin took over as Health Officer. He shared his office with Dr. Snow, until the latter's death in 1888, when he succeeded him in the office of City Registrar.

Dr. Snow took a keen personal interest in the young man and utilized the remaining years of his life to lay the proper foundation for Dr. Chapin's career.

Continued on page 36

PROVIDENCE SUPERINTENDENTS OF HEALTH



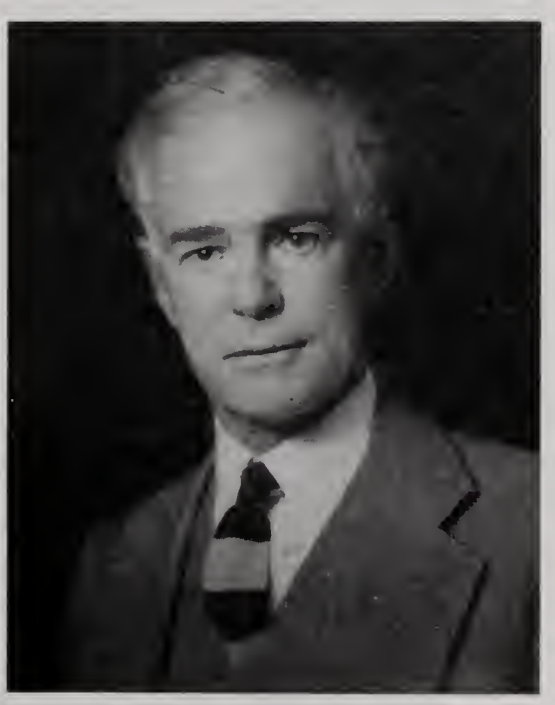
EDWIN M. SNOW, M.D.
1855.....1884



CHARLES VALUE CHAPIN, M.D.
1884.....1932



DENNETT L. RICHARDSON, M.D.
1932.....1935



MICHAEL J. NESTOR, M.D.
1935.....

PUBLIC VACCINATION

Drs. L. W. Clifford and G. L. Collins having been appointed by the Board of Health to perform public vaccination, will vaccinate such persons as require it in their offices.

Dr. Clifford's office
No. 106 South Main Street
Office hours from 12 to 2 p.m.

Dr. Collin's office, No. 48 South Main Street
Office hours from 2 to 4 p.m.

ALBERT PABODIE, *City Clerk*

. . . As published in the PROVIDENCE DAILY JOURNAL, April 4, 1848

CITY HEALTH DEPARTMENT

continued from page 34

Among the interesting anecdotes of that period is the one on reports. In Demember 1884 Dr. Chapin began to prepare himself for the report that was to be ready for the Council for the year. He searched the office for previous reports and was able to find only the first report for the year ending July 1, 1857. He thereupon asked Dr. Snow what was done with the other reports. Dr. Snow informed him that inasmuch as the City Fathers had not deemed it advisable to carry out any of the recommendations printed in the first report, he saw no reason why he should print any more reports since they would only repeat his recommendations.

Dr. Chapin continued in his offices until January 1932 when he retired after 48 years of service. His most favorite phrase, which he ascribed to his friend Professor Winslow, was "Thinking is a painful process". However, he did not spare himself any of that pain. He took facts and figures and then thought them out and reached the proper conclusion. He tried to face every problem with an open mind. He admitted the difficulty, but like a true scientist he became open minded in all his dealings. In 1928, on his election to the presidency of the American Public Health Association in Chicago, a position he had declined for years, he publicly stated that he had to overcome his own prejudices because of his work. Through his work he had learned that proper conclusions are derived only from facts and figures after proper evaluation and thought, and that prejudices prevent such proper thinking. He thus became one of the first exponents of fair employment policies in practice.

It was during Dr. Chapin's tenure of office that the science of medicine made such great strides in the diagnosis, the treatment and control of communicable diseases. He himself played a great part in this advance by clearly analyzing the scientific facts.

Dr. Chapin also realized that since "Public Health is Purchaseable" and since public monies are being spent, the public is entitled to the most for its money. He was one of the first to attempt to evaluate public health procedures. He also evaluated public reaction to public health problems.

The people of the City of Providence should be proud of their Medical Profession and that profession in turn may be proud of their representatives who have so clearly laid out the fundamentals of efficient public health control and have carried these principles to their practical conclusions.

These men are Drs. Snow, Chapin, D. D. Richardson and M. J. Nestor, leaders in their field and in their profession.

RHODE ISLAND MEDICAL SCHOOL

The following gentlemen are associated for the purpose of giving instruction in the various branches of Medical Science vi:2

Theory and Practice of Medicine and Obstetrics JOSEPH MAURAN, M.D.

Clinical Surgery
LEWIS L. MILLER, M.D.

Principles and Practice of Surgery
HENRY W. RIVERS, M.D.

Chemistry and Toxicology
THOMAS P. SHEPARD, M.D.

Anatomy and Physiology
GEORGE L. COLLINS, M.D.

Materia Medica and Pharmacy
GEORGE THURBER

Lectures or examinations will be had daily. Students will have access to a good medical library, a cabinet of anatomical preparations and plates, and will have abundant opportunities of seeing practice.

Ample facilities will be afforded for pursuing practically the study of anatomy.

Chemistry and Pharmacy will also be taught practically, and Materia Medica illustrated by specimens.

For further information, application can be made personally, or by letter, to

G. L. COLLINS, *Secretary*
48 South Main Street

. . . As published in the PROVIDENCE DAILY JOURNAL, January 31, 1848

ANESTHESIA IN RHODE ISLAND*

ALBERT H. MILLER, M.D.

The Author. *Albert H. Miller, M.D., Consulting Staff, R. I. Hospital.*

ABBE HENRI BREUIL once said—"Every being, every thing, every institution, derives, at least in greater part, from its antecedents, and is, in turn, at least in greater part, the starting point of the realities which follow it." In this paper there is a study of the development of anesthesia in Rhode Island from its beginning to the present, with the prospect for the future. It begins with the establishment of a department of anesthesia at the Rhode Island Hospital on the first of January in the year 1901.

At that time the hospital had a capacity of about 300 beds; there was an active staff of thirty visiting physicians and surgeons with a resident pathologist and six resident internes; there was a nursing staff of six graduates with sixty-eight student nurses.

The cost of maintaining one patient for one day was $1.58; 22% of the patients paid the hospital rate of $1.60 per day; 70% of the patients were free.

The mortality rate was 8%. In 1900 there were 1165 operations done with a mortality rate of 7.04%; two years later, in 1902, there were 1522 operations with a mortality of 4.26%.

The main buildings had been completed in 1868, thirty-two years before. In that period the outpatient department had been removed from its original position in the main building to a new location at the Eddy Street gate; Ward F. had been converted from a dormitory for the help to a ward for private patients; a home for nurses had been built on Lockwood Street. In May, 1900, the new South West Pavillion had been completed and occupied. It served all the women patients and the children. The new laboratory occupied the top floor. Contagious diseases were admitted and were treated at the City Ward, a building located at the rear of the main hospital.

The hospital was primarily a charitable institution, with little provision for treatment of private patients. A few private patients could be accommodated in Ward F.; they were mostly private patients of the hospital and not of the practitioner who treated them. Operations in private practice were done for the most part in the patient's home.

The surgeon or his assistant prepared for an operation on the night before, sterilizing instruments, dressings and ligatures. In the morning the surgical team of surgeon, assistants and anesthetist met at the home of the patient where the nurses were already preparing the operating room. This would likely be the kitchen with the kitchen table for an operating table. For more important operations a bedroom might be chosen, with carpets taken up, sheets covering the walls and a table moved in from the kitchen or dining room. It was necessary to choose a well lighted room as portable lamps were not often available. Although we knew ether to be imflammable, it was often administered beside the kitchen stove or with open gas lights. Chloroform could not be used in the presence of an open flame because the drug was decomposed by an open flame into an irritating gas which would set everyone coughing.

A few surgeons operated at the Broadway Sanitarium, located at the corner of Ringgold Street. Later came the Parade Street Hospital, the Hope Hospital on Benefit Street, the East Side Hospital next door. In a second floor hall on Weybosset Street, Dr. Eccleston conducted the Emergency Hospital, where men injured on the New Haven Railroad were treated. Homeopathic Dr. Waldo Stone had the Channing Hospital on Smith Street. The Homeopathic Hospital of Rhode Island was on Morris Avenue at Montague Street. St. Joseph's Hospital stood where it does today. The Providence Lying-In Hospital had moved to State Street behind the State Capitol. The Lying-In Hospital was already looking up although few respectable women would yet endanger their reputations by bearing their children in a hospital.

Surgical practice followed the monetary condition of the patients. The poor went to the hospital; operations in the middle class were done at home by Prrovidence surgeons; the wealthy could summon surgeons from a distance; Dr. Maurice W. Richardson and Dr. W. M. Conant from Boston, Dr. John Erdmann from New York, Dr. John B. Deaver from Philadelphia, Dr. J. M. Finney from Baltimore. This was in accordance

continued on next page

* Read at a meeting of the Friday Night Medical Club of Providence, October 17, 1947.

with custom, it had nothing to do with the skill of the surgeons. No doubt that of all these patients those at the Rhode Island Hospital received the best treatment.

The operating room of the Rhode Island Hospital was located at the rear on the fourth floor of the central building. It was reached by a stairway which led from the third floor corridor and by an elevator which ascended from the first floor. Adjoining the operating room were rooms for etherization and for recovery of surgical patients. A gallery for spectators overlooked the operating room. The narrow stairway which led to the gallery also provided entrance to the rooms which housed the new X ray department. The hospital was lighted by gas; in the operating room a ring of flickering gas jets was suspended over the operating table by a long pipe which descended from the height of the cupola.

The front half of the operating room floor was taken up by a large, bright and cheerful ward, Ward E., originally occupied by the library and meeting place of the Rhode Island Medical Society. The library had been transferred to the Chapel, a lofty hall filling the rear half of the second and third floors of the main building. Here were held solemn meetings of the staff and of the corporation, and the examinations of internes.

Among the first 100 surgical cases at the Rhode Island Hospital ether was administered thirty-four times. The practice of etherization either with Morton's inhaler or with Dr. Mason Warren's ether sponge had become well established before the opening of the hospital in 1868. The first notable improvement in ether administration was made by Dr. L. H. Prince of Chicago, who in the year 1879 recommended the drop by drop method with free admixture of atmospheric air. Dr. Prince stated:—"The free admixture of air is an old idea, and has had from time to time, able supporters, but it has not been generally adopted." In New York City, Dr. Thomas L. Bennett was achieving great success by administration of the gas ether sequence with a closed inhaler. He followed the English practice, rebreathing from a closed bag with scant renewal of fresh air.

In 1900 neither of these developments had penetrated Rhode Island. At the Rhode Island Hospital ether was administered with a closed cone made from a butcher's cuff of straw, covered with oiled silk and a towel, hermetically sealed at the apex. Inside, a sea sponge was placed designed to be soaked with liquid ether. The patient reclined upon a stretcher placed on a cot bed. An interne put the cone, charged with ether, over the patient's face, an orderly restrained him. After a more or less brief struggle the patient succumbed to the effect of the anesthetic. The orderly then picked up one end of the stretcher, the interne took the other and the patient was carried to the operating room and deposited on the operating table.

The anesthetics were administered by the junior internes. There was some supervision by the senior internes and by the surgeons. Ether was the routine anesthetic. Chloroform was extensively used despite statistical proof that it was more dangerous than ether. It was the routine anesthetic in obstetrics; it was frequently administered to children. The use of nitrous oxide was limited to dentistry.

The department of anesthesia at the Rhode Island Hospital was instituted on January 1, 1901. To improve the administration of anethetics, to secure anesthesia safer and more comfortable for the patients, we devised a method which combined the advantages of Dr. Prince's drop method with the gas ether sequence of Dr. Bennett. The butcher's cuff was discarded and replaced by a cone made from newspaper, open at both ends and covered with a towel. We experimented with cones of different heights; the deeper the cone the greater the amount of rebreathing and the greater the concentration of carbon dioxide. The sea sponge was replaced by a wad of washed gauze held in place by a safety pin. Instead of charging this evaporating surface with a large quantity of ether, small amounts could be added at frequent intervals. One of the surgeons presented us with a S. S. White dental nitrous oxide apparatus; we were then ready to try the gas ether sequence. The method which resulted was described in a paper published in the Annals of Surgery for December, 1899, under the title:—"Nitrous oxide and Ether Anesthesia by the Open Method." The method was simple; it consisted of securing a brief anesthesia with nitrous oxide, rapidly replacing the gas inhaler with the ether cone, maintaining the anesthesia by adding ether through the distal end of the cone.

This method was soon widely adopted not only in Rhode Island but in other localities. I personally gave demonstrations of the method at the Massachusetts General, at the Boston City Hospital, and at Bellevue in New York. The method, at first crude, was constantly improved; by fitting the cone with an adjustable ring of metal two inches in width, thus preventing liquid ether from soaking into the cone and also forming an evaporating chamber at the top of the cone; by measuring the amount of liquid ether as used, considering it to be foolish and unreasonable to administer a powerful agent in unmeasured amounts. The gas inhaler was discarded in favor of a gravitational method, depending upon the heavy specific gravity of the gas to hold it within the cone. Oxygen was added to the nitrous oxide and a constant flow of oxygen maintained throughout the duration of the oper-

ation for the reason that ether displaces up to 45% of the atmospheric air inspired during anesthesia. Replacement of this amount of oxygen keeps the blood properly oxygenated, prevents shock, and reduces postoperative nausea and vomiting.

On January 1, 1901, we knew of no precedent to follow in establishing a department of anesthesia. I started out by arranging informal talks on anesthetics with the junior internes and by practical supervision of their work. As other local hospitals followed the example of the Rhode Island Hospital in founding a department of anesthesia, the work became beyond the capacity of one man and assistant anesthetists were appointed. Four assistant anethetists were appointed at the Rhode Island Hospital. Each served a term of three months a year. The assistant anesthetist on duty supervised the work of the interne anesthetists; he could be called upon to supervise anesthesia in any difficult case but could not be required to administer an anesthetic personally unless compensated. Upon the representation that it was difficult to persuade men in private practice to devote time to this confining work, the Trustees ruled that all members of the department of anesthesia would immediately have full staff privileges. An appointment as assistant anesthetist then became especially desirable.

The first assistant anesthetists were

Frank M. Adams
Charles O. Cooke
Robert C. Robinson
S. Newell Smith, Jr.

Subsequent appointments were

J. E. Kerney
Bertram H. Buxton
Edward S. Cameron
Peter Pineo Chase
Frank H. Mathews
Paul C. Cooke
Alfred F. McAlpine
Wilfred Pickles
John A. Picozzi
Alfred L. Potter
Ralph DiLeone
William P. Davis
Julius G. Kelley
Frank H. Littlefield
Robert R. Baldridge
Joseph J. Johnson
Charles J. Ashworth
A. V. Migliaccio
Adolph W. Eckstein
Meyer Saklad
Kenneth G. Burton
Orland F. Smith
Edmund C. Laurelli
Edward R. Ruhmann

The assistant anesthetists carried on their duties faithfully; there were few complaints about the efficiency of their work. The duties of the chief anesthetist came to be limited to general supervision and a series of lectures on anesthesia for internes and nurses. In 1932, Dr. William L. Leet was appointed as resident physician; he was interested in anesthesia and carried on many of the functions of a resident anesthetist. In 1935 Leo V. Hand was appointed full time resident anesthetist. Dr. Hand studied the patients before and after operation; he did a lot of valuable research work.

The staff of anesthetists held conferences from time to time, regularly near the time when the services changed and new internes took on their duties. At a conference held in February, 1912, the Providence Society of Anesthetists was formed. The first annual meeting was held in February of the following year with Dr. James T. Gwathmey of New York as principal speaker and with short papers by members of the Society. Subsequent meetings were addressed by Walter Boothby and Frank Richardson of Boston and by E. I. McKesson of Toledo. Dr. Charles Cooke as President arranged a joint meeting with the Providence Medical Association at which Dr. Gwathmey was again the principal speaker.

On the opening of the Memorial Hospital in 1910, routine anesthesia was entrusted to graduate nurses. They were carefully instructed and frequently supervised. The result was so satisfactory that nurse anesthetists were employed at the Rhode Island Hospital. The reason was that there was more work in anesthesia than the junior internes could do without interference with their other duties. There was constant complaint from the medical staff that their internes were busy giving anesthetics at the time of regular morning rounds; surgeons complained that their internes might be riding the ambulance at the time when they would operate. It was arranged that the internes give the anesthetics for surgical cases, the nurses for all special services.

Two nurses were chosen from the graduating class of 1917, Geraldine M. Cathels and Eva M. Steere. They became very expert in the use of ether and of nitrous oxide oxygen. They resigned after two years of service but were followed by a succession of nurse anesthetists who kept up the reputation assured from the start. The most notable record was made by K. Gladys MacLeod, who served as nurse anesthetist for almost twenty years. She herself became an expert and trained a succession of efficient nurse anesthetists. Each nurse anesthetist agreed to stay with the chosen institution for at least one year. We refused many

continued on next page

requests for a short course of instruction for nurses from other centers.

The work of the nurse anesthetists was so good that the superintendent of nurses and the superintendent of the Rhode Island Hospital decided to reform the entire system of the department of anesthesia and turn the work over to the nurses. The Trustees vetoed this idea on the representation by the chief anesthetist that training in anesthesia is essential to the education of a surgeon; that a surgeon who has not had experience with anesthetics is not well fitted for his surgical work.

The Rhode Island Hospital was almost alone in this position. Most of the hospitals in the country discharged their medical anesthetists and replaced them with nurses. The apology for nurse anesthesia was that the nurses would be supervised by the surgeon or his assistants. The objection was that if hospital residents were without experience with anesthetics there would soon be no one on the hospital team competent to supervise the work of the nurses. The real reason for the wide adoption of nurse anesthesia was financial; the hospital having nurse anesthetists on small salaries gained a substantial income from the fees charged for their services.

Organized groups of anesthetists, especially in the Mid-west, fought this condition in several ways; in some states anesthesia was defined as practice of medicine and legally restricted to medical graduates; members of anesthetic societies were forbidden, on pain of expulsion, to train or supervise nurses as anesthetists; it was sought to make anesthesia too difficult and too complicated for the nurses, by introduction of new agents and intricate apparatus. None of these measures were effectual; the proponants of nurse anesthesia were high in the councils of the College of Surgeons and the American Medical Association. It took time to prove that nurse anesthesia unsupervised was dangerous for patients; the lesson was costly in human lives. We still suffer an aftermath of too numerous agents and methods, many of them distasteful to patients, some too dangerous for serious consideration.

In Rhode Island we did not seek legal control of nurse anesthesia; we did not waste hospital funds on purchase of complicated apparatus; we continued to instruct and supervise our nurses in spite of protests from the societies.

For thirty-five years we used the open nitrous oxide ether sequence as the routine anesthetic, with a few brief interludes:—In 1906 ethyl chloride was adopted for use in minor operations and as a preliminary to etherization. Used by our open method it seemed an eminently satisfactory anesthetic; it was administered in more than 6,000 cases without mishap. Then a fatality occurred which was certainly due to the anesthetic; ethyl chloride was promptly abandoned as a dangerous agent.

Nitrous oxide oxygen anesthesia was widely publicized by manufacturers of the gases and apparatus for their use. We began the use of this anesthetic in 1909. It became popular with the surgeons, patients asked for it; in 1915 half of our cases were done with nitrous oxide oxygen but its use gradually diminished in Rhode Island from that time. We do not know that nitrous oxide oxygen was directly responsible for any fatalities but from the study made by Courvillein of Los Angeles there is little doubt that the anesthetic contributed to some unexplained deaths. In New York, Dr. Thomas L. Bennett, greatest American anesthetist, abandoned the use of gas-oxygen after a short trial; he decided that it was a dangerous agent. Dr. J. F. Baldwin of Columbus, in his address as president of the Ohio State Society, reported ten deaths from nitrous oxide oxygen in his home town. He declared nitrous oxide to be the most dangerous anesthetic in use for major operations; its exploitation chiefly for pecuniary gain and advertising.

All objections to the use of nitrous oxide oxygen hold for the other gas anesthesia which have since been exploited to take its place:—ethylene, acetylene, cyclopropane. We used ethylene very little, the others not at all. They are explosive agents, so inefficient that their anesthetic effect must frequenly be supplemented by ether. There is no surgical gas apparatus to be purchased on the market which does not have an ether attachment.

In 1916, Dr. Robert E. Farr of Minneapolis perfected the technic of regional anesthesia and recommended its use for most of the operations of surgery. He came to Providence and was entertained as a guest at a meeting of this club. Soon regional anesthesia by Dr. Farr's technic became quite generally adopted; it seemed that the day of the general anesthetist was about finished. Gradually the vogue of regional anethesia abated but its effect on the quality of surgery was lasting. The sensibility of the conscious patient was respected; operating room technic became quiet and decorous; surgeons learned to approach the body cavities with consideration and with tact. At the Mayo Clinic, Alvarez was able to carry out his significant observations on reflex response to operative manipulation.

In 1928 Dr. Kingman introduced the use of a dilute novocain solution for securing relaxation under light general anesthesia. His technic was adopted by a number of surgeons and is extensively used at the present time. When we were using nitrous oxide oxygen we were able to maintain satisfactory anesthesia for some difficult rectal

operations under this anesthetic with the aid of novocain.

Dr. Gwathmey's ether oil colonic anesthesia was used for a good many operations. It was displaced by two rectal agents, avertin and paraldehyde. Avertin was widely advertised by its German manufacturers, with extensive propaganda in many medical journals. It was administered by Sir Francis Shipway to King George V for several operations; it was given at least once to Henry Ford. Avertin is tri-brom-ethanol; the presence of bromine in the formula made us suspicious of its safety. We used avertin in one-half to three-quarters of the recommended dosage with comparative safety. We gave up its use because of a tendency of surgeons to ask for larger doses.

We were responsible for the introduction of paraldehyde rectal anesthesia. Except for its penetrating odor and its attraction for all the flies in the neighborhood it was a valuable method of anesthesia. We discontinued use of paraldehyde when we found that barbiturates given by mouth secured equally satisfactory results.

We avoided intravenous sodium amytal, a method fostered at the Mayo Clinic but finally discarded as dangerous. We avoided intravenous pentothal as a method suitable for the exegencies of military use but too dangerous for civilian practice.

In 1901, when the department of anethesia was organized, anesthetics were everywhere administered without preliminary examination, without preliminary medication, there were no records of anesthesia. The advantage of a preliminary physical examination would seem to be self evident but its adoption met with considerable opposition in Rhode Island and with more active resistance in some other centers. Some surgeons seemed to consider it a personal affront that their patients should require a physical examination before a contemplated operation. The idea gradually made headway and now is routine in most places. In 1913 we began to take the systolic blood pressure of all patients before operation. By 1916, blood pressure tests during the operation had become routine.

In 1901 records were written by the internes in bound books. The records were inspected for legibility and completeness by the visiting committee of the Trustees at their regular Thursday visits. The system was efficient; the records were not immediately written but were up to date every Thursday. A separate chart for the anesthesia was first introduced at the Rhode Island Hospital. It was designed for protection of the internes who administered anesthetics, they were likely to be blamed for any surgical complication that occurred. In the first two years of the department of anesthesia surgical mortality had for some reason been reduced from 7.04% to 4.26%, but fatalities still occurred during or following operations. If the anesthetist could show a record kept at five or ten minute intervals throughout the operation he could prove that he had at least been on the job and that the fatality was not due to negligence on his part. The anesthesia charts were conscientiously kept. They were introduced at St. Joseph's Hospital and at the Memorial Hospital. In 1920 the National Anesthetic Society introduced a standard anesthesia chart which has been used without change for the past twenty-seven years; it is used in many hospitals.

The present status of anesthesia is indicated by a recent report of the Committee on Survey of the American Society of Anesthesiologists. This committee contacted every hospital in the country which has more than 25 beds. The report states:— that the anesthetic nurses dominate the personnel, numerically, in all but the smallest hospitals; that the biggest increase planned for anesthetic staffs will be in anesthetic nurses; that many surgeons prefer to work with nurses since there is less division of authority in the operating room; that anesthesia training is given in only a small percentage of the hospitals and that is concentrated in the larger hospitals; that most hospital executives think that a trend toward physician anesthetists is desirable because of the increase in the number of anesthetic agents, and the narrowing margin of safety in anesthesia.

It appears, from this report, that anesthesia has become more complicated and more dangerous but that the anesthetic nurses continue to dominate the situation. In Rhode Island, however, anesthetic nurses have never presented a serious problem. For the increased number of anesthetic agents and the narrowing margin of safety attending their use the remedy would seem to be a limitation of the number of anesthetic agents, a simplification of the methods of administration, and a program for education in the fundamentals which underly anesthetic practice for both doctors and nurses.

In the choice of the anesthetic agents and methods which will survive, not the inclination of the anesthetist nor the convenience of the surgeon, but the safety of the patient will be the factor which finally will prevail.

WOMAN'S AUXILIARY MEETING

The next meeting of the Woman's Auxiliary will be held on Thursday, March 4, 1948, at 2 p.m. at the Rhode Island Medical Society Library. The guest speaker at this meeting will be Dr. Edward A. McLaughlin, Director of the State Health Department.

The RHODE ISLAND MEDICAL JOURNAL

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THE PROVIDENCE MEDICAL ASSOCIATION CENTENNIAL

A CENTENNIAL CELEBRATION naturally calls for a review of the history of the organization involved. The task can be onerous, or, as in the case of the Providence Medical Association, delightfully interesting. To those who have been privileged in recent months to explore again the detailed minutes of the scientific assemblies of the largest and oldest district medical society in the State one fact stands out in monumental manner. That is the excellent reporting of the medical and health history of the years, presenting for posterity an example of the constant search of the physician for scientific truths in his quest of the secrets of the healing art.

This quest undoubtedly played a major part in the urge to record in writing, and eventually in printing the clinical experiences of the members of the Association through the years. The carefully penned minutes of the Association offer excellent summaries of the discussions that took place in the Franklin Society rooms on North Main street for most of three score years prior to the building of the Rhode Island Medical Society Library.

But as the Association entered its second half century of existence there developed a strong desire to print its transactions in a journal of its own. In 1893 the Rhode Island Medical Science Monthly had made its appearance under independent sponsorship as "a journal of reform and progress in the Medical Sciences". Local physicians contributed articles to this publication, and with its third volume, in 1895, it became the Atlantic Medical Weekly. In 1898 it merged in the Philadelphia Medical Journal, continuing under that title for five years before it merged with the New York Medical Journal.

Independent sponsorship meant little or no control over phases of the publication, such as advertising, that could be most damaging to the medical profession. Possibly this factor was the prime one that prompted Dr. Frederick T. Rogers, one of the most learned physicians of his day, to urge the Association at its meeting on May 1, 1899, to publish on its own the transactions of its meetings. His request resulted in the appointment of a committee that reported at the December meeting in the same year, with the subsequent action by the Association to publish a quarterly titled THE PROVIDENCE MEDICAL JOURNAL. Dr. George D. Hersey was named as editor, and Dr. Rogers as business manager. Thus was initiated the first medical publication in this State under complete medical society

control.

By way of explanation and greeting to the profession the new Journal announced editorially in its initial issue, in January, 1900, that

> "If there was ever a medical journal which did not have to hunt around for an excuse of existence it is the PROVIDENCE MEDICAL JOURNAL.
>
> "It is not founded to enrich its proprietors or to impoverish its advertisers, to furnish a medium for the exuberance of medical ideas or to add fame or glory to any man or set of men. It has nothing to sell and no favors to grant. It is published simply because the Providence Medical Association has enterprise enough to attempt to collect and publish the valuable papers read before various local societies, to report the interesting cases which occur in our hospitals, and to record for future reference the medical matters of interest to the profession of this state which would not otherwise be made a matter of record. ..... For this year the JOURNAL will be sent to every physician in the state, and, unless we mistake the profession, enough who are not members of the Providence Medical Association will appreciate the effort made and will pledge us their subscriptions at a nominal price to enable the Association to continue its publication.
>
> "As a matter of fact we are rather proud of the JOURNAL, both of its appearance and contents. There is no reprinted or abstracted matter; it is original from cover to cover and so it will continue."

Proud the Association may rightfully be of the excellent book it issued to its membership through the years. Its service to the entire profession of this State during a time when there was no publication by the State Medical Society marks a contribution that will never be forgotten. An even greater contribution to the solidarity of the profession was that made in 1916 when the Association agreed to turn over its literary achievement to the Rhode Island Medical Society, and for a sale price of one dollar!

Thus the RHODE ISLAND MEDICAL JOURNAL came into full grown existence after a healthy adolescence under the guidance of the Providence physicians. With the change in name and ownership came a change in the editorial staff to allow for statewide representation. Through the years, however, members of the Providence district society, the largest unit in the State society family, have continued to be the major contributors to the publication, and they have continued the scientific standard and literary tone of its predecessor. Today this Journal ranks with the finest state medical society publications in the country.

Again, in 1943, the Providence Medical Association made another outstanding contribution to this JOURNAL when it merged with it the four year old PROVIDENCE MEDICAL NEWS, a sprightly eight page non-scientific monthly containing excellent editorials, informative articles on social and economic changes in medicine, and pertinent news of interest to the profession locally.

We have related our debt to the Providence Medical Association as regards its publications. We are mindful also of the fact that within the first year of the Association, in 1849, the proposal was made that part of the funds raised by the annual assessment should be used for the purchase of medical journals. This was the start towards the State Medical Society's Library, now housing more than 35,000 volumes. For almost the hundred years of its existence the Association has furnished the profession, locally at first, and later statewide with the erection of the library building, with the outstanding American and foreign medical journals.

Then, too, in 1938 the Providence Medical Association blazed a new trail, for New England and the greater part of the East, when it re-organized and established a central office with a fulltime executive secretary in charge. This venture proved successful to the extent that five years later the executive officer was assigned similar duty for the State Medical Society.

For the entire medical profession of the State, therefore, the editorial staff of the RHODE ISLAND MEDICAL JOURNAL felicitates the Providence Medical Association on the attainment of its 100th year, and at the same time expresses to it the sincere appreciation of every physician for the progressive and successful programs it has initiated through the years for the benefit of organized medicine in Rhode Island.

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ADENOCARCINOMA OF THE BREAST

Report of a Case Recurring 27 Years After Radical Mastectomy

THOMAS PERRY, JR., M.D.

The Author. *Thomas Perry, Jr., of Providence, Surgical Resident, Rhode Island Hospital.*

RECURRENT ADENOCARCINOMA of the breast usually manifests itself within a few years following mastectomy. A case seen at the Rhode Island Hospital with recurrence twenty-seven years after operation, therefore seems worthy of record. The anatomic relationship of the recurrent tumor to the original lesion appears to make the diagnosis a certainty.

This case stimulated a study of the records of the Rhode Island Hospital Tumor Clinic, where 130 cases of recurrent adenocarcinoma of the breast were treated between 1932 and 1942 with recurrence times as follows:

TIME	NO. CASES	TOTAL %
0 — ½ yrs.	38	29.3
½—1 "	29	51.6
1 —1½ "	16	63.9
1½—2 "	14	74.7
2 —2½ "	9	81.6
2½—3 "	6	86.2
3 —4 "	7	91.6
4 —5 "	5	95.5
5 —6 "	1	96.3
6 —7 "	2	97.8
7 —8 "	0	97.8
8 —9 "	2	99.3
9 —10 "	0	99.3
10 —20 "	0	99.3
22 — "	1	100

As will be seen, 95.5% recurred within five years, after which cure is deemed reasonably certain. However, there is a scattering of much later recurrences. It should be noted that cases were first seen at the Tumor Clinic in 1932, thus excluding recurrences after fifteen years at the very most, unless the patient reported to the clinic with recurrence already present. Among those deemed five-year cures there are undoubtedly some who are going to have late recurrences, thus altering the above table.

A fairly thorough search of the literature reveals the following five reports of cases recurring after twenty-five years: I. Case of E. Boeckel[1]. Very large breast tumor removed in 1827. Recurred locally after twenty-nine years. Report does not state type of operation. Breast tissue may have been left behind and a new tumor formed. There was no microscopic diagnosis. II. Case of Verneuil[2]. In discussing a colleague's paper, mentions the case of "une dame de Constantinople" who had a recurrence thirty years afterward "determinée par le microscope". III. Case of A. Heurtaux[3]. Recurrence locally and elsewhere thirty years after simple mastectomy and axillary dissection. IV. Case of E. J. Steward[4]. Recurrence after thirty-one years. There were no microscopic sections, but clinical evidence is excellent. V. Case of Ernest Daland[5]. Recurrence locally after thirty-four years. Again no microscopic sections, but good clinical evidence. This is the longest recorded time interval between operation and recurrence.

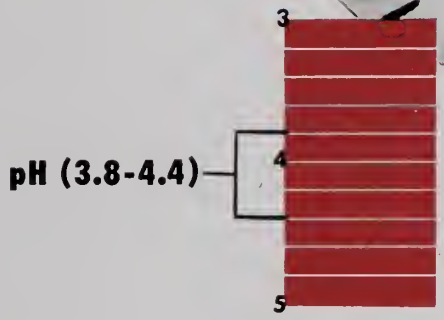
To these may be added the following case report:

M.M.L. entered the Rhode Island Hospital June 2, 1918. Two years previously she had noted enlargement of the entire left breast and later a lump within it. This eventually became slightly tender, causing her to seek medical aid. There was a past history of post partum abscess in the same breast. On physical examination the entire left breast contained a "hard, lumpy mass about three inches in diameter in the outer lower quadrant." No axillary nodes were palpable. A radical mastectomy was done on the second hospital day. As the specimen was not examined microscopically, we have only the following gross description by a competent pathologist: "Specimen consists of breast, pectoral muscles and axillary tissue. In breast is a small, firm tumor, cut surface of which is dense, gray, and granular. In lymph nodes are areas resembling tumor."

For the purposes of this presentation, it is not necessary to give the details of the patient's second admission (Hospital No. 403601) from January 26 to March 1, 1946. Suffice it to say she was in excellent health until seven months prior to entry, when she developed increasing nausea, vomiting, weakness, and weight loss. The important physical findings were emaciation and evidence of fluid

continued on page 46





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*Baehme, E. J.: Trichamonas Vaginalis Vaginitis; Diagnasis, Treatment, Causes of Failure in Treatment, S. Clin. North America 25:545 (June) 1945.

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

ADENOCARCINOMA OF THE BREAST

concluded from page 44

in the left chest. There was no sign of tumor in the old mastectomy scar or in the axilla. The patient pursued a hectic downhill course, during which she had numerous paracenteses of the left chest, producing up to 1400 cc. of bloody fluid. At the time of her demise on the thirty-fourth hospital day the exact cause of death was not known, but malignancy was suspected.

The important findings at post mortem (No. A-46-64) are given briefly. There were no tumor nodules in the region of the old scar or axilla and no evidence of tumor in the opposite breast. The left pleural cavity contained 1300 cc. of watery, brown fluid. The left visceral and parietal pleurae were studded with hard, white tumor nodules which frequently coalesced to form masses of tumor. In the region of the lymph node chain about the site of the obliterated internal mammary artery there was a solid plate of tumor two centimeters thick. Similar tumor tissue was found throughout the left lung, the pericardium, and the mediastinal lymph nodes in masses ranging from very small to four centimetres in diameter. There were also distant metastases to the abdominal lymph nodes, both adrenals, and the gallbladder.

Histologically, the lesions were in no way inconsistent with adenocarcinoma of the breast, although sections showed marked variation. Typically, there were cords of cells with round or oval pyknotic nuclei and little cytoplasm. A moderate amount of connective tissue surrounded these cords (Fig. 1). In other regions fibrous stroma formed a more prominent part of the tumor. In places groups of large acini were formed with irregular papillary infoldings. In one adrenal the tumor was quite similar to that seen in the ductile type of breast malignancy (Fig. 2).

Other autopsy findings were brown atrophy of the internal organs, including the heart, chronic passive hyperemia, and atrophy of the stomach mucosa and muscularis.

Comment

It is regrettable that there were no microscopic sections taken of the original tumor. However, the opinion of the pathologist that the gross specimen represented typical carcinoma with axillary lymph node involvement can hardly be questioned. Furthermore, it seems significant that the maximum recurrence at autopsy was along the internal mammary chain of nodes directly beneath the old mastectomy scar. In view of these findings, there seems to be little doubt that this case represents a recurrent adenocarcinoma of the breast with survival for just short of twenty-eight years. The remarkable fact is that she was symptom-free for all but the last seven months of this time. One can merely theorize as to whether the tumor was slowly growing all this time, or whether, after a long period of dormancy, a small focus of residual tumor became active. The clinical course suggests the latter chain of events.

Summary

1. Figures are given for recurrence time in 130 consecutive recurrent mammary carcinomas.
2. Cases from the literature recurring after twenty-five years are quoted.
3. An additional case of adenocarcinoma of the breast recurring after twenty-seven years is reported.

THOMAS PERRY, JR., M.D.

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1. Lehr, D.: Proc. Soc. Exper. Biol. & Med. 64:393, 1947.

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FRACTURE OF THE UPPER END OF THE FEMUR

EDWARD B. PAYNE, M.D.

The Author, *Edward B. Payne, M.D., former Orthopedic and Fracture Resident at Rhode Island Hospital. Now stationed at Khartoum, Anglo Egyptian Sudan.*

THIS STUDY of 779 fractures of the upper end of the femur is made as an evaluation of advance in treatment and for comparison of methods used in relation to prognosis. These fractures comprise the cases seen from 1939 to 1946 at Rhode Island Hospital and treated by members of the Department. The work was instituted under the direction of the Chief of Service. It was not thought necessary to stretch the report by a division between male and female cases because the ratio has been established by many other studies, and the usual proportion was found (206-573). In this series there were 317 trochanteric fractures, of which 12 involved the greater trochanter only. Forty-five were subtrochanteric. Three hundred eighty were fractures of the neck (and head in 2) and 37 were of the base of the neck. The line of division between these cannot be made with exactness but all near the base of the neck and susceptible of fixation with nail only or pins were included as basal fractures. This permits comparison in the first period between two inclusive similiar groups in one of which no surgery was done. There were 16 patients who sustained two of these fractures with about equal division between the same and opposite sides, and between trochanteric and neck fractures.

All cases seen for the first time in this clinic are included. Thus there is a small number of old untreated or inadequately treated cases. Only about 3% of cases were associated with severe trauma. Among these there were 11 deaths. The average age ranged from 67.7 years in 1939 to 71.7 years in 1946. The youngest patient was 1 year and the oldest was recorded as 108. Trochanteric fractures predominate in males of all ages. In females this is true only of the group over 80, the incidence increasing with age. In ordering the hospital data four age groups were used because it appeared that any further breakdown would give numbers too small to be of significance. Comparison has been made between the periods 1939-44 and 1945-46. This is because internal fixation was extended to pertrochanteric fractures in the last two years, and second because at this time antibiotics first came into general use. This reduced deaths due to pneumonia and other infection.

Deaths in the hospital are first reviewed, incidence for fracture necks of the femur in Table I and for intertrochanteric fractures in Table II.

	Cases operated			Cases not operated			Total cases		
1939-44 Age..... 0	No.	Deaths	%	No.	Deaths	%	No.	Deaths	%
Below 60	44	0	0	14	5	35.5	58	5	8.6
60-69	61	8	13.	17	4	23.5	78	12	15.4
70-79	67	8	12.2	33	21	63.6	100	29	29.0
80 and over	32	8	25.	23	14	60.9	55	22	40
Total	204	24	11.6	87	44	50.5	291	68	23.4
1945-46									
Below 60	19	0	0	2	0	0	21	0	0
60-69	21	1	4.7	5	1	20	26	2	7.7
70-79	37	3	8.1	12	2	16.6	49	5	10.2
80 and over	17	3	12.6	4	2	50	21	5	23.8
Total	94	7	7.4	23	5	21.7	117	12	10.3
Percentage 7 yrs.			11.4			44.5	408	80	19.4
For 1946 only	39	2	5.1	7	3	42.9	46	5	10.9

TABLE I

Almost 20% of fractures of the neck of the femur still do not come to surgery. These are for the most part minor cracks, pathological fractures or very bad cardiac cases. With fractional spinal anesthesia even some of these latter may be reasonably undertaken, confining the anesthesia as far as possible to the region with weight adjusted solutions.

	Cases operated			Cases not operated			Total cases		
1939-44 Age	No.	Deaths	%	No.	Deaths	%	No.	Deaths	%
Below 60	none						51	07	13.7
60-69							64	6	9.5
70-79							93	17	18.3
80 and over	none						82	27	32.9
Total	none						290	57	19.7

1945-46									
Below 60	2	0	0	10	0	0	12	0	0
60-69	5	0	0	12	0	0	17	0	0
70-79	9	2	22	24	3	15.2	33	5	15.2
80 and over	5	0	0	14	7	50	19	7	36.8
Total	21	2	9.5	60	10	16.6	81	12	14.8
Trochanteric, 7 yrs.			9.5	350	67	19.1	371	69	18.4
All cases, 1946	58	4	6.8	33	7	21.2	91	11	12.1
All cases, 7 yrs.	299	33	11.	460	116	25.2	779	140	19.1

TABLE II

From these figures it will be seen that deaths among the unoperated were more numerous for fractures of the neck of the femur than for intertrochanteric in the 1939-44 period. This may be partially explained by the lack of protection now afforded these patients. In the second period with progressive relative and absolute increase in operative fixation, post-operative mortality is reduced more than ⅓. Post-operative mortality may be expected to remain higher for trochanteric fractures because of the longer procedure and the greater average age. Surgery has steadily increased among the more aged.

The figures given in tables I and II are gross, with no consideration of duration of the disease or presence of another or primary pathology. In the first period 5 deaths shortly after arrival were due to trauma, 5 to terminal malignancy and 7 in the first week to pneumonia. Four were only seen a week or more after injury. There were 14 for whom no adequate treatment was available. Mortality under established treatment was 20.4% against a 21.6% gross in 1939-44 . . . Three 48 hr. deaths in the last 2 years were due to trauma and delayed admission, reducing mortality to 10.6% from a gross of 12.1%. All but one of the deaths associated with severe trauma (14) were cases of trochanteric fracture.

More than a dozen methods of definitive initial treatment have been used in this hospital. These have included traction, Bryant and Australian, casts, various uses of screws, nails, pins and plates, Whitman reconstruction, osteotomies and arthrodesis. Of open operations 98% have been internal fixation at the fracture site. Nine patients were reoperated to improve position in fractured necks of femurs. Most of these came to non-union. Fourteen were reoperated for non-union, osteotomy being done in most cases or athrodesis if the head was absorbed.

Complications were all those common to geriatric practice with pneumonia reported in more than ⅓ of cases. Malignancy was present in 2½%. Half the deaths in 1946 were complicated by pneumonia despite antibiotic treatment. In recent years the understanding of fluid and electrolytic balance and of protein supply for the aged has gone far to lower rates. Disturbances in these factors were not recorded until recently. They were probably present in 3 of the 9 deaths in 1946. Eleven infections are recorded. Table III is in relation to discharge status of patients and its connection with the subsequent history. Figures on non-operative treatment of fractured neck of the femur here recorded might profitably be repeated for trochanteric traction treatment now.

TABLE III

Those discharged as bed patients were either maintained in traction or were considered incurable. A few were post operative and expected to be mobilized. The second group in Table III were discharged in traction in most instances except for six with minimal injury and little if any displacement. In a wide effort at follow up 18 patients are known to have expired within 6 mo. out of 649 discharged. The patients were from all walks of life. Many were indigent and dropped from contact or were sent to the infirmary. Of the 18, eleven were bed patients at discharge and 6 were fractured necks treated by traction. Twenty-four more of this group were reported dead but date of decease was not recorded. Of the 607 patients remaining for study of functional results 107 were followed for 2 years or more, 60 neck fractures. An added 49 of each type were followed for one to two years. From these non-union was found in 28 necks or 26%. Another 5 were seen to have developed non-union before the end of a year. Six unoperated

Year	1939	1940	1941	1942	1943	1944	1945	1946
Bed patients discharged	9 14%	17 21%	11 16%	18 29%	13 11%	11 12%	12 13%	5 6%
Fr. Neck femur discharged By traction	3 1 subcap	8 1 Ca A 1 Polio A	2 1 impact.	7	10 1 inc. A	7	8 1 Ca	1 recovered
Deaths in traction Fr. Neck of femur	6	7 (1 Ca)	3	9	8 (2 Path)	11 (1 Ca)	3	2
Infections	4			2		2	1	2
Path. fractures		1	1		2	2	3	1
Total malignancy		4	2		5	4	4	2
		(1 chondrosa.)			(1 sarcoma)			

continued on next page

necks secured union. These occurred in cracks without displacement or in impactions. Six patients had pain sufficient to curtail walking. More than half had some pain usually associated with weather change, prolonged position or fatigue, but use of the member was fairly satisfactory or better. X-ray findings of ultimate results were revealing in that many in which the bone appeared indifferently well re-aligned were functionally satisfactory to good. In contrast a certain few with excellent anatomic position complained of pain. It is the impression that in the original reductions AP views showed better position than the lateral. These latter may have given some indication of impending non-union where position otherwise was good. Of the cases followed 12 nails had to be removed. One was bent. Of those originally nailed, four, on a second occasion were pinned and one renailed. In 15 cases Moore pins were removed. In 3 cases nail fixation was tried when pins had failed. Once Moore pins were reinserted. In 2 cases nail and pins were both used. Of all cases operated 13 nails were reported as showing some encroachment on the joint structures. In one serious acetabular damage resulted. In 27 pinnings encroachment was reported, but function was usually not affected. Second fixations were rarely successful. Beside repetition of fixation for non-union, intertrochanteric osteotomy was done in 10 cases, Whitman reconstruction in 2, and arthrodesis in 3 cases.

In two cases intertrochanteric fracture resulted in non-union. All trochanteric surgery was mechanically successful except one case in which a Blount blade cut through the neck during manipulation of the patient in bed. Of these cases 9 had Blade fixation and 12, Nail with Thornton attachment. In later experience this has been known to separate if not firmly flat against the shaft. Functional results have been very satisfactory. Blade fixation has also been tried with osteotomy. Of 12 cases reported as fracture of the greater trochanter only, one was later found to have severe joint destruction. Otherwise they were not significant.

From these figures it will be seen that the hazard of surgery in poor risk patients is being challenged with increasing frequency and with apparently more satisfactory results than in the more conservative era. Thus fewer patients are being consigned to an early death or permanent bed status. The number of patients that would not have been rehabilitated and those saved from serious mental aberation by this more courageous surgical practice does not show in the records, but comparison with earlier reports gives an indication. With increase in surgery mortality has become lower, patient days in hospital reduced, rehabilitation shortened, strength of the patient conserved, and mental status improved. With increasing factors of protection wider application of surgery is in view.

Sincere thanks are in order for the cooperation of all the members of the staff and clinic for their abundant professional and clerical assistance without which this report would have been impossible.

More detailed comparative study of internal fixation methods is anticipated by the staff.

Khartoum
15 Oct. 1947

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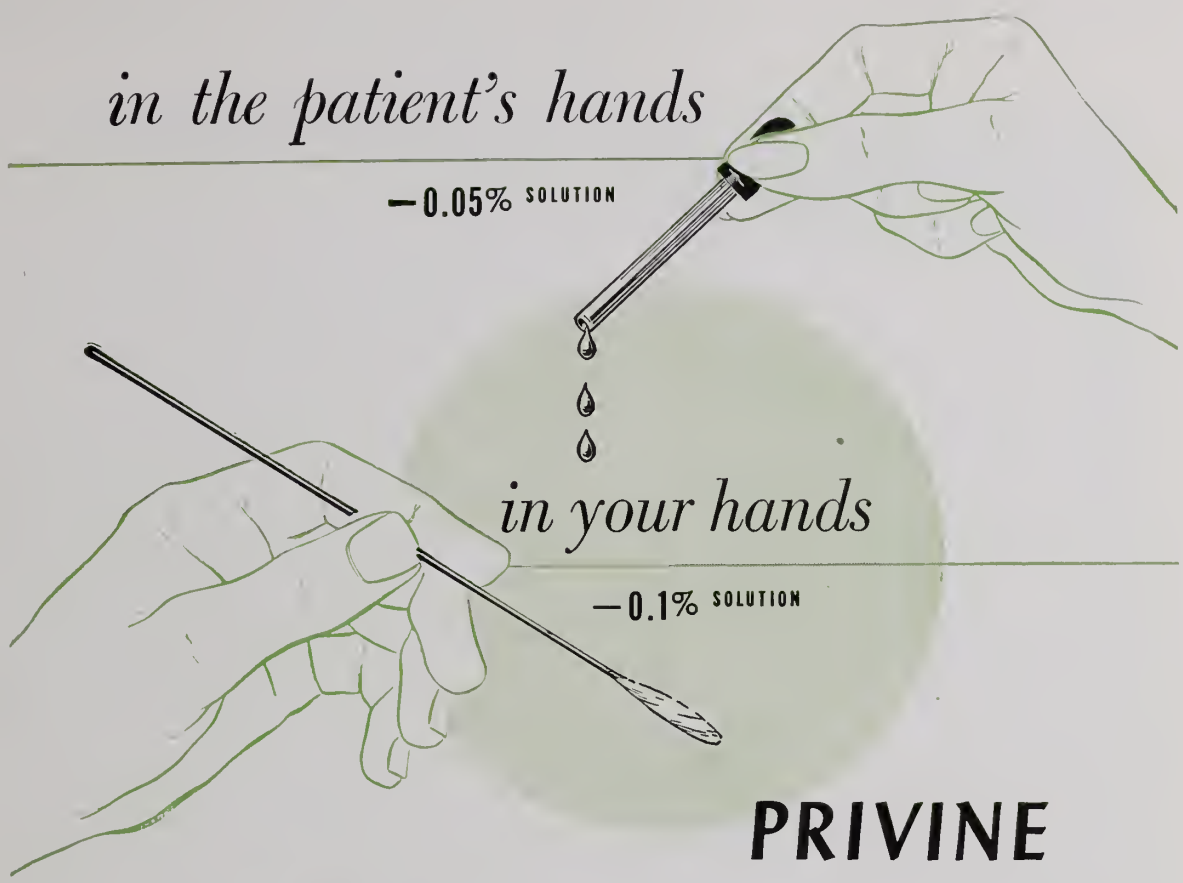
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THE PSYCHOLOGICAL LABORATORY AT BUTLER HOSPITAL

GERALD R. PASCAL, *Chief Psychologist*

FOR SOME TIME now, those findings of experimental-theoretical psychology, loosely lumped together and called *clinical psychology,* have been finding an ever widening scope of application in psychiatric thinking and practice. The scientific approach and the techniques of the experimental psychologists are being applied with ever increasing intensity to the problems of psychiatry. The practical skills of the psychologist as aids both in diagnosis and treatment, are receiving more recognition by psychiatrists. This welding together of the experimental techniques of psychology and the discipline of psychiatry was given great impetus during the war. In great part, forward-looking psychiatrists deserve the credit for the accomplishment of this necessary union. They invited psychologists to do research with their patients. They, as members of the medical profession, provided the necessary authority which made psychologists members of the psychiatric team during the war. They, now in civilian life, provide the conditions so that psychologists have ample opportunity to demonstrate their ability to make contributions to both psychiatric theory and practice. Dr. Arthur H. Ruggles, Superintendent of Butler Hospital, has been a leader in this movement, and it is against this background and on his recommendation that the trustees decided to found a psychological laboratory at Butler Hospital.

As originally planned the laboratory was to serve three primary functions. Listed in the order of their importance to the planners, they are, (1) research, (2) service, and (3) training. Although research and service functions are listed separately, in the minds of the planners, research is thought of as a service, the service without which the progress of day-to-day service functions could not proceed. Training, of course, is a necessary adjunct to progressively better service. The Psychological Laboratory, therefore, is founded on the idea of service, in conformance with the policy of Butler Hospital.

The Psychological Laboratory came into being in the Spring of this year. It was given almost the entire third floor of Sawyer House. It now has six consultation rooms, one instrument room, and one large conference room. Its present staff consists of two senior psychologists, one full-time intern and one secretary. A beginning has been made in the acquisition of apparatus for services and research. Thus far, the laboratory has sound recording equipment, reaction time apparatus, an ergograph, a tachistoscope, a psycho-galvanic reflex apparatus (on order), and a memory drum (on order). In addition, the laboratory is equipped with a great variety of psychological tests both for routine testing and special purposes. Although the research function of the laboratory comes first in importance, direct service functions, at present, occupy the most time, and this will necessarily be so until the staff of the laboratory is increased. We shall, therefore, first discuss, very briefly, the service functions, and then proceed to discuss research aims and projects in progress, and finally the training functions of the laboratory.

At present the routine psychological battery for patients with so-called functional disorders includes the Wechsler-Bellevue, Rorschach, Thematic Apperception, Minnesota Multiphasic, Bender Gestalt, Kuder Preference, and Cornell Index tests. Where organic involvement is suspected, selected tests are given to tap psychological capacities at various levels in an attempt to estimate both the location and probable extent of the organic damage, and recommendations for retraining where this is indicated. With respect to the functional disorders, psychological testing attempts to complement the psychiatric interview. Insofar, as possible, on a quantitative basis, it provides information as to the severity of the patient's reaction, the nature of the reaction, probable contributing factors in the etiology of the reaction, and in some cases, prognosis for psychotherapy and recommendation as to practical handling. Where the patient can probably obtain some help from a particular vocation or avocation as suggested by his test results, this is also indicated.

Selected cases are sent by the psychiatrists to the Psychological Laboratory for vocational counselling, and psychotherapy. Where the patient's reaction is of such a nature that supportive counselling and vocational guidance are indicated, the patient may be sent to the laboratory for vocational testing and counselling. In such cases the patient is given a battery of tests, and in addition, seen for several interviews. The problem usually

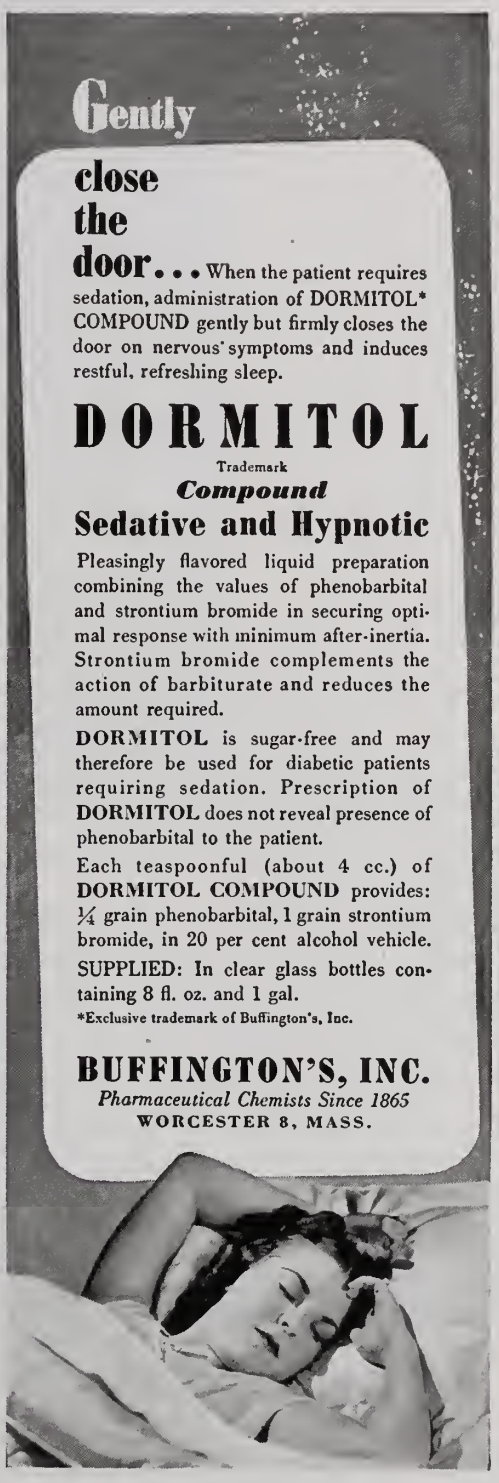
involves the patient's understanding of his own emotional needs and the realistic appraisal of these and his assets in the choice of vocation which he, himself, must make. In some cases, patients free of psychosomatic complaints are sent to the laboratory for psychotherapy, when, in the opinion of the psychiatrist, these cases can benefit from the particular skill of the psychologist. In individual instances where the psychologist has had special training or experience, seriously disturbed patients are referred to this psychologist. In all referrals for testing, counselling or psychotherapy, the decision to make the referral is up to the psychiatrist who is responsible for the case and in whose care the patient remains as long as he is being tested or treated in the Psychological Laboratory.

Thus far, with the exception of an occasional case referred by the Veterans' Administration Mental Hygiene Clinic, the service facilities of the laboratory are limited to the physicians of Butler Hospital. It is hoped, that sometime in the future these facilities may be offered to other physicians in the community. In addition, it is planned that some psychological service functions will be offered to industry.

Research at the laboratory is slowly getting underway. A recent task, accomplished at the request of the Superintendent, has been a survey of nurses' attitudes toward various aspects of psychiatric nursing. The accumulation of data on the before-and-after comparisons of psychological test results on cases of frontal lobotomy is a long term, continuing study. This study has as its aims (1) an attempt to assess the effects of lobotomy and (2) an endeavor to find tests of prognostic value.

At present, three projects of an experimental nature are in process. The first concerns the reaction of psychotics to group situations. This project has two purposes, as follows: (1) to understand more fully the dynamics of the group situation with psychotic patients, and (2) to develop a more effective technique applicable to group psychotherapy for psychotic patients. The second project has to do with the development of a simple projective technique which may help to discriminate between normal individuals and seriously disturbed individuals. The third project concerns itself with the study of the sexual adjustment of patients as this is revealed on certain projective tests. Several other projects are planned, but these must wait on the future development of the laboratory. One project, now in the planning stage, proposes to set up a research ward of psychotic patients, these patients to be given special study and treatment, in order to learn more about the etiology and treatment of psychotic disorders. Not all research, however, is to have an immediate practical application. Some will be theoretical in na-

continued on next page



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ture, seeking to contribute to psychological and psychiatric theory, a most necessary function of research.

As to the teaching functions of the laboratory, they are two-fold in nature. The first aspect of the training program is the teaching of pertinent psychological findings to the staff of psychiatric residents. At present, the formalized portion of this teaching consists of a weekly seminar on psychological testing. It is hoped that some time in the future another seminar series can be inaugurated which will teach the application of experimental findings in the field of human learning to psychiatric problems.

With respect to the other aspect of the training program, it is felt that this laboratory should be a place where other psychologists can be trained in the practical applications of psychological knowledge as members of the psychiatric team, and in the application of research techniques to the problems of psychiatry. With this in mind, the trustees have authorized the training of psychological interns and residents. The number of them that will be accepted has not yet been determined. The requirement for the intern in psychology is the masters degree with appropriate, applicable, graduate courses in psychology and related fields. The requirements for the resident in psychology is the PhD degree in psychology plus one year of internship.

The Psychological Laboratory at Butler Hospital was founded by the trustees in a spirit of service to the community. A profound conception of service places research first in order of importance; for the research of today is the service of tomorrow. And it is within this framework that this laboratory operates. It is primarily a research laboratory. This orientation does not mean, however, that the day-to-day service functions will be neglected. On the contrary, research in this field might easily become sterile without a close connection with service functions. It is precisely this aspect of the situation which promises much for the future; for here is the opportunity for the discipline of psychology, at one time primarily academic, to apply its techniques to the pressing problems of psychiatry in a milieu conducive to the necessary close cooperation between psychiatrists and psychologists. The past history of research in this field indicates that it is this collaboration which promises most in the way of results.

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PROVIDENCE IN 1848

It might not be amiss at this time to picture briefly the Providence of this time, a growing city of approximately 40,000 people, the majority of whom lived on the west side of the river. In every direction the city was stretching out its arms.

The discovery that anthracite might be used to develop steam had initiated a rapid growth of cotton and woolen mills, engine works, foundries, jewelry factories and many minor industries, all of which served to offset the decline in shipping which had been the salient feature in the development of the early city.

Gas lamps were being installed by the Providence Gas Company in the city centre to replace the former naptha lamps which in turn had superseded whale oil lamps in various other sections of the city.

The telephone was still in the future, although the Rhode Island Magnetic Telegraph Company was already incorporated with power to connect different places in the State by aerial lines of wire, and to connect such lines with other lines without the State for the transmission of telegraphic messages. The manner in which this was to be done was incomprehensible to most people, and many of them delivered themselves of the firm opinion that the thing was simply impossible.

In 1847 the first train had run from Providence to Worcester, and the building of the new red-brick Union Station (on the site where the new Post Office is now erected) replaced the terminus at India Point of the Boston and Providence railroad. The water route by steamer to New York was either direct, or by train to Stonington and thence by boat, since the railroad from Stonington to New York was not yet in existence.

As the horse car did not make its appearance until the winter of 1863-64, the only commercial transportation to the outlying villages of Pawtucket, Olneyville, Elmwood and Pawtucket was by omnibus. The period was truly one of the days of the "horse and buggy" doctor who could be seen at all hours making his round of house visits.

A Brown student of this era might observe the early relics of the State's history at the Rhode Island Historical Society library which stood on Waterman street. As he followed the path down College Hill he would pass the then recently erected Athenaeum, and had he paused to enter during the fall of 1848 he might have seen Edgar Allan Poe carrying on his courtship there with Sarah Helen Whitman.

Market Square, a tantalizing spot for pedestrian and motorist alike today, was a scene of confusion even then, with numerous farm wagons and private carriages assembled outside the city market. The City Building graced the square, and was to serve as the City Hall from 1865 until the erection of the present building on Exchange Place in 1878.

Elisha Harris of Coventry was Governor, and for this office he received the sum of $400 annually. The population of the State was estimated at 125,659, of whom the Rhode Island State Total Abstinence Society claimed 41,000 pledged members. The Providence City government was headed by Thomas Burgess who incidentally was also president that year of the Franklin Society in whose rooms the Providence Medical Association was to hold its meetings. At the City Hall at 108 South Main street the many public officers included one George Thurber who was Inspector of Saleratus and Bi-Carbonate of Soda, and one Daniel V. Ross whose duties were those encumbent upon the Inspector of Liquors to Ascertain Proof.

Reverend Francis Wayland was president of Brown University which then boasted a student enrollment of 155. Two physicians, Drs. Samuel B. Tobey and Levi Wheaton were listed among the thirty-five Trustees of the University. Of the City's approximately 40,000 population some 5,600 were children attending the 40 public schools taught by eleven gentlemen and seventy-four ladies. Of the City's receipts of $117,156.82 the sum of $23,288 was allocated for school expenses.

The City directory listed 51 physicians and surgeon, of whom 23 were Fellows of the Rhode Island Medical Society, when Dr. Rivers was host to the first meeting of the Providence Medical Association at his North Court street office. In addition to this list the directory included a roster of 23 Botanic, Thompsonians, Mesmeric, and Indian doctors. The nurse roster was limited to a total of 13.

And as we hear the President of the Association for the present year of 1948 report a return flight from California to Rhode Island in a single day, making but two stops, to be present for the 101st annual meeting of the Association, we try to recall how the train announcer's voice must have thrilled the 1848 traveller at the Union Station three times daily as he announced train departures for Boston — stopping at Seekonk, Perrins' Crossing, Dodgeville, Attleboro, Tobey's Corner, Mansfield, Foxboro, Sharon, Canton, Dedham Low Plain, Toll Gate, Jamaica Plain, and Roxbury!

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R. I. NOMINATION FOR AMA GENERAL PRACTITIONER AWARD

In placing Dr. Edmund D. Chesebro in nomination for the General Practitioner Award to be given by the American Medical Association the Rhode Island Medical Society believes that he rightfully holds a unique place in the roster of American physicians. The Society also feels that the evaluation of the man as a general practitioner must go beyond the mere listing of his academic background, any civic honors he might have attained, and his age, and must evaluate the man and his contribution in relation to the community in which he has lived and served, and the profession which he has inspired.

For fifty-seven years Dr. Edmund D. Chesebro has maintained continuously the general practice of medicine on the same street in Providence, and his influence has been statewide. Alert and active he still continues his round of visits of patients in the city daily.

His lifetime of service for the improvement of general medical practice has never lessened from the days of his externeship at the old Chambers Street Hospital in New York, where he introduced, in 1890, the custom of continuously boiling instruments over an Argand Burner while on duty as a better antiseptic method than the then practiced immersion in a carbolic acid solution. He established, in 1901, the children's department of St. Joseph's Hospital in Providence, and he continued as its chief for the ensuing ten years. He won the admiration and respect of interns at Rhode Island Hospital for several decades by his deep insight of the problems of general medical practice, and he has thereby contributed tremendously to the medical education of the physicians now serving the people of the city of Providence, and the state of Rhode Island. He has held the leadership of both his district and state medical societies; he has been a regular attendant at medical meetings, ever seeking to broaden and improve his knowledge of medicine.

Attendance at the American Medical Association meeting in Colorado forty-nine years ago marks the only break in his record of continuous attendance at the commencements at Brown University in the sixty years since his graduation.

Only the oldest citizens can recall how Doctor Chesebro, making his visits on foot when he started practice, made as many as five house calls in one night, one of them more than two miles from his office. Others will recall him bicycling to see his patients, and later utilizing a horse and carriage, and finally the automobile. That all who have come within his practice have found in him a true physician was revealed when a check of his records for the month of February, 1943, showed that he attended relatives of one hundred and thirty-seven families that he had served as medical advisor over a period of thirty years.

Political and civic honors have held no attraction for Doctor Chesebro. He has left a far greater contribution, however, in his untiring and unself-



© FABIAN BACHRACH

EDMUND D. CHESEBRO, M.D.

ish devotion to his patients, and to the profession he has honored so highly, by his profound influence in the general practice of medicine in this community. His own philosophy on the practice of medicine is well summarized in his own words, that

"As I reminisce, going back over a period of sixty years, it is hard to realize that so many changes have taken place during my one period of medical activity, and I realize that most of those changes have been accomplished through the efforts of scientists, laboratory workers, and specialists in medicine. The young specialists of today are doing a most wonderful work, and of course the end is not yet. Many undreamed of discoveries and improvements will be effected by the continued courage and work of those men and women.

"I believe, however, there is still room for the general practitioner. It has been estimated that the well qualified family physician can give more satisfactory service in eighty-five per cent of all the real and imaginary ills about which the doctor is consulted; and when the specialist's services are needed, as a rule, the family doctor is much better qualified to suggest whom to call than the average well wishing friend and neighbor. Every family needs a family physician."

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5 Registered Pharmacists

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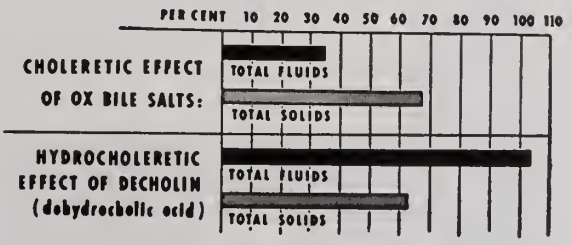
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Ivy, A. C., et al: Am. J. Dig. Dis. 7:333 (Aug.) 1940.

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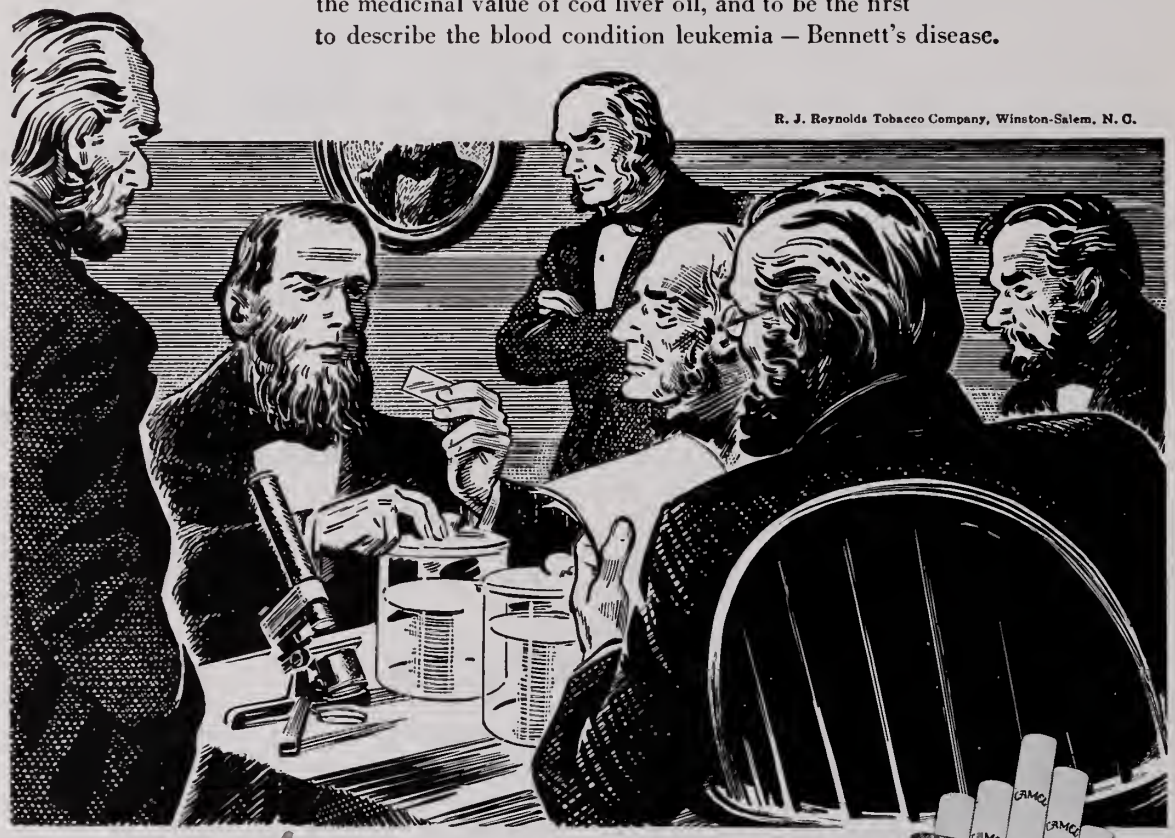
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ELKHART, INDIANA

Experience is the Best Teacher

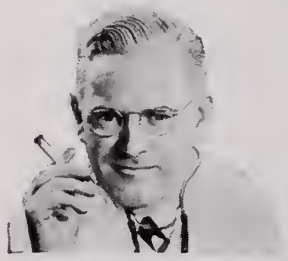
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PRESIDENTS

1848	S. Augustus Arnold
1849-51	Joseph Mauran
1852	R. Brownell
1853	Hervey Armington
1854	J. W. C. Ely
1855	C. W. Parsons
1856-58	George L. Collins
1858	R. Brownell
1859	George P. Baker
1860	F. H. Peckham
1861-63	W. O. Brown
1863	George Capron
1864	E. M. Snow
1865-68	George L. Collins
1868	George A. Pierce
1869	Howard W. King
1870-72	George W. Carr
1872-74	J. W. Sawyer
1874	C. T. Gardner
1875	G. H. Kenyon
1876	H. G. Miller
1877-79	S. S. Keene
1879	W. E. Anthony
1880	O. C. Wiggin
1881-83	E. M. Harris
1883	A. E. Ham
1884-86	W. J. Burge
1886-89	John W. Mitchell
1889-91	Chas. H. Leonard
1891-93	Robert F. Noyes
1893	F. B. Fuller
1894	C. V. Chapin
1895	W. R. White
1896	G. T. Swarts
1897	H. Terry
1898	B. Whitford
1899	C. H. French
1900	J. M. Peters
1901	F. T. Rogers
1902	S. A. Welch
1903	J. E. Mowry
1904	G. A. Mathews
1905	F. L. Day
1906	E. D. Chesebro
1907	E. B. Smith
1908	W. J. McCaw
1909	J. H. Davenport
1910	J. C. Rutherford
1911	F. P. Capron
1912	Henry C. Hall
1913	Frank E. Peckham
1914	John T. Farrell
1915	Arthur T. Jones
1916	H. G. Partridge
1917	F. E. Burdick
1918	Wm. F. Flanagan
1919	H. W. Kimball
1920	D. L. Richardson
1921	F. T. Fulton
1922	N. Darnell Harvey
1923	Wm. B. Cutts
1924	G. W. VanBenschoten
1925	Albert H. Miller
1926	Roland Hammond
1927	Henry J. Hoye
1928	E. S. Brackett
1929	Arthur H. Ruggles
1930	C. S. Westcott
1931	John E. Donley
1932	L. C. Kingman
1933	James W. Leech
1934	Chas. F. Gormly
1935	W. P. Buffum
1936	W. S. Streker
1937	Peter Pineo Chase
1938	A. M. Burgess
1939	H. C. Messinger
1940	John G. Walsh
1941	Murray S. Danforth
1942	Henry E. Utter
1943	Emery M. Porter
1944	Albert H. Jackvony
1945	B. Earl Clarke
1946	Paul C. Cook
1947	Guy W. Wells
1948	Philip Batchelder

SECRETARIES

1848-50	J. W. C. Ely
1850-52	Henry P. Pratt
1852-54	E. M. Snow
1854	George P. Baker
1855-58	W. O. Brown
1858-60	E. A. Crane
1860-63	H. G. Stickney
1863	Timothy Newell
1864	E. T. Caswell
1865-69	W. H. Traver
1869-71	E. M. Harris
1871	O. C. Wiggin
1872-74	G. H. Kenyon
1874	J. W. Mitchell
1875	W. H. King
1875-78	V. O. Harden
1878-80	E. S. Allen
1880	G. D. Hersey
1881-84	W. R. White
1884	F. B. Fuller
1885-87	H. Terry
1887-90	S. A. Welch
1890	F. M. Eaton
1891-93	J. H. Kingman
1893-95	F. L. Day
1895-97	Jay Perkins
1897-July '98	C. E. V. Kennon
July '98-1901	H. P. Lovewell
1901-03	H. G. Partridge
1903	H. A. Cooke
1904-06	D. Churchill
1906-08	R. Hammond
1908-10	J. B. Ferguson
1910-12	F. M. Adams
1912-14	L. B. Porter
1914-19	C. O. Cooke
1919-21	R. G. Bugbee
1921-36	Peter Pineo Chase
1936-41	H. A. Lawson
1941-43	Frank B. Cutts
1943-45	Frank W. Dimmitt
1946	Frank B. Cutts
1947-	Daniel V. Troppoli

TREASURERS

1848-50	Lewis W. Clifford
1850-54	C. W. Parsons
1854-56	E. M. Snow
1856-59	J. W. C. Ely
1859-61	E. M. Snow
1861-63	G. W. Carr
1863-68	W. O. Brown
1868-72	L. L. Swan
1872-74	F. H. Peckham, Jr.
1874-82	W. H. Traver
1882-85	Byron Whitford
1885-87	G. T. Swarts
1887-89	W. A. Tremaine
1889-91	H. Terry
1891-93	J. H. Davenport
1893-95	F. B. Sprague
1895-99	E. B. Harvey
1899-18	W. A. Risk
June '18-Nov. '18	F. T. Rogers
Nov. '18-Feb. '37	C. F. Deacon
Feb. '37-1943	W. P. Davis
1943-45	Herbert E. Harris
1946	William P. Davis
1947	J. Murray Beardsley

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY
Report of Meeting Held on November 24, 1947

A REGULAR MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Monday, November 24, 1947. The meeting was called to order at 8:30 p.m. by President Arthur H. Ruggles. The following Delegates were in attendance at the meeting:

Kent
Rocco Abbate, M.D.

Newport
Louis E. Burns, M.D.
James Callahan, M.D.

Pawtucket
Charles L. Farrell, M.D.
Henry Hanley, M.D.
Robert Henry, M.D.
Earl J. Mara, M.D.

Providence
Charles J. Ashworth, M.D.
Robert Baldridge, M.D.
Philip Batchelder, M.D.
Alex M. Burgess, M.D.
B. Earl Clarke, M.D.
Paul C. Cook, M.D.
G. Edward Crane, M.D.
Morgan Cutts, M.D.
William P. Davis, M.D.
Donald L. DeNyse, M.D.
Peter F. Harrington, M.D.
William A. Horan, M.D.
Albert H. Jackvony, M.D.
Walter S. Jones, M.D.
Louis I. Kramer, M.D.
Herman A. Lawson, M.D.
Frank I. Matteo, M.D.
Eward A. McLaughlin, M.D.
John C. Myrick, M.D.
Joseph C. O'Connell, M.D.
Michael J. O'Connor, M.D.
Edwin B. O'Reilly, M.D.
Arthur H. Ruggles, M.D.
Daniel V. Troppoli, M.D.
Frederick A. Webster, M.D.

Washington
Hartford P. Gongaware, M.D.
Julianna R. Tatum, M.D.

Woonsocket
Augustine W. Eddy, M.D.
Joseph Reilly, M.D.

Also in attendance were Dr. H. Lorenzo Emidy, Mr. Charles Williamson, Legal Counsel for the Society, Dr. Stanley Sprague, Chairman of the Industrial Health Committee, Dr. James P. Deery, member of the Industrial Health Committee, and Mr. John E. Farrell, Executive Secretary.

REPORT OF THE SECRETARY

Dr. Morgan Cutts called to the attention of the House the important actions taken by the Council since the last meeting of the House of Delegates. The report, which had been mimeographed and distributed to the House in advance of the meeting, was accepted as prepared and it is made part of the official minutes of the meeting.

RECOMMENDATIONS FROM THE COUNCIL

Delegate to the AMA: The Secretary submitted recommendation from the Council that the Delegate to the AMA be elected at this time in order that he may participate at the mid-winter meeting to be held at Cleveland early in January.

It was moved that the House of Delegates elect Dr. Herman A. Lawson of Providence as Delegate and Dr. Peter Pineo Chase of Providence as Alternate Delegate to the American Medical Association House of Delegates for the years 1948 and 1949. The motion was seconded and unanimously adopted.

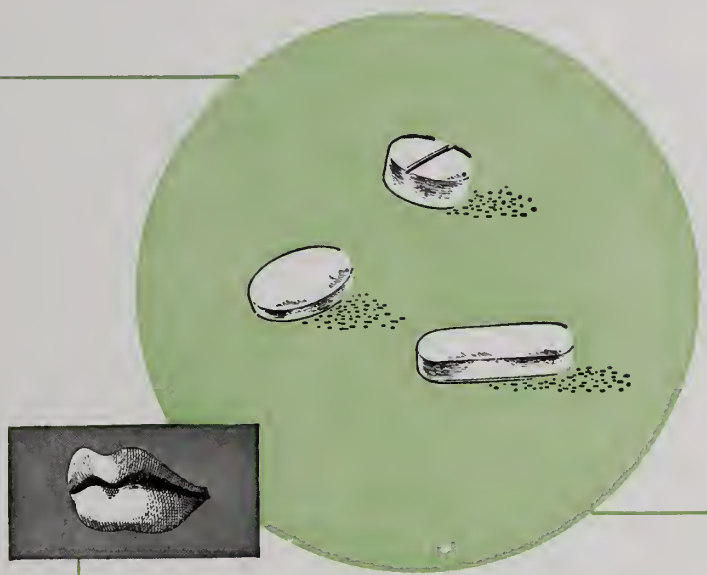
Budget and Dues for 1948: Dr. Charles J. Ashworth, Treasurer, reported that in accordance with the By-Laws he had submitted a budget for 1948 to the Council which had been approved by that body. He briefly reviewed the increased expenditures for the repairs and maintenance of the Library and the operation of the Society.

It was moved that the House of Delegates accept and approve the budget already submitted by the Treasurer to the Council and approved by that body; and further, that the annual assessment for 1948 be $40 for active members in practice more than one year and $25 for active members in their first year of practice.

continued on page 64

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HOUSE OF DELEGATES MEETING

continued from page 62

Free Afternoons of Physicians: The Secretary reported on the problem of providing physicians on Wednesday afternoons in some communities and he reported that the Council recommended that the House of Delegates urge each district society to develop a plan for the staggering of afternoons off by members of its society for the better protection of the public.

It was moved to approve the recommendation. The motion was seconded and adopted.

Standard Membership Form: The Secretary reported that the State Society certifies members for the American Medical Association, and therefore the Council feels that a standard membership form should be used by each of the district societies. Therefore, the Council recommends that the House of Delegates adopt as the standard membership application form for each district medical society the form now used by both the Providence Medical Association and the Pawtucket Medical Association.

The motion was seconded and adopted with a recommendation that a copy of the form be sent to each district society secretary.

General Practitioner Award of the AMA: Dr. Cutts reported that the Council had received voluminous information relative to Dr. Edmund Chesebro, for 57 years continuously in the practice of general medicine in Providence, with the request that he be considered as a nominee from Rhode Island for the General Practitioner Award of the AMA.

It was moved that the House of Delegates accept Dr. Edmund Chesebro as one of the candidates. The motion was seconded and adopted.

MEDICAL PHASES OF THE WORKMEN'S COMPENSATION ACT

Dr. Ruggles reported that the Industrial Health Committee had a report to make to the House after which at his request Professor Taft, Chairman of the State Workmen's Compensation Law Commission, and Senator Fred Broomhead, member of the Commission, wished to address the House.

Dr. Charles Farrell reported that he had appeared with Dr. Sprague before the Commission and had presented the statement of the Industrial Health Committee refuting the charges that physicians' fees for workmen's compensation services were excessive. He also reported that the commission had expressed the desire to meet with the House of Delegates and assurance had been given that such a meeting would be arranged.

Dr. Ruggles called to the attention of the House the fact that the report of the Committee on Industrial Health which included recommendations for the improvement of the administration of the medical phases of the State Workmen's Compensation Act had been submitted to each member. He asked for action on the report.

Dr. Walter Jones moved that the House accept the report and adopt the recommendations of the Committee on Industrial Health. The motion was seconded. There was brief discussion in which Dr. Sprague, Chairman of the Committee, explained some of the recommendations.

The motion was adopted.

Professor Taft, Chairman of the Commission, was then invited to address the House. He reported on some of the findings of the Commission as regards the medical program of the Workmen's Compensation Law, and Senator Broomhead discussed the role of the Curative Center in the community.

The complete presentation of these speakers and the discussion entered into with them by the members of the House is incorporated in the official minutes of the meeting on file with the Society.

At the conclusion of the discussion Dr. Charles Farrell moved that the House thank the Commission members for meeting with the House of Delegates and explaining the problems of interest to the medical profession regarding the Compensation Law. The motion was adopted with a rising vote.

Dr. Harrington submitted two recommendations for possible addition to the report of the Committee on Industrial Health, which in turn would be transmitted to the Compensation Law Commission. After brief discussion it was moved that the recommendations be referred to the Committee on Industrial Health for their decision. The motion was adopted.

HEALTH INSURANCE COMMITTEE

Dr. Rocco Abbate, Chairman of the Committee on Health Insurance, reported on the program of the new committee which is assisting in develop-

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PROVIDENCE 9, R. I.

ing the prepaid surgical insurance program. He reported that the committee, in accordance with the action of the last meeting of the House of Delegates, had been augmented by the addition of Dr. Henri E. Gauthier of Woonsocket, Dr. Samuel Adelson of Newport and Dr. Louis Cerrito of Westerly. He reported that each of the district societies had endorsed the program and that 498 members of the Society had already enrolled as participating physicians.

He also reported on a recent meeting held with the conference committee on health insurance of the insurance industry. He stated that three companies had already notified the committee that they are preparing contracts and will participate in the program and that other insurance companies had indicated orally that they anticipate submitting policies before January.

Dr. Abbate stated that the committee anticipates an expenditure for printing of forms and brochures necessary for the use of the membership in forwarding the program. It was moved that the House accept the report of the committee and that it authorize the Treasurer to pay for such necessary expenses as may be incurred by the committee in the furtherance of its work. The motion was seconded and adopted unanimously.

POSTGRADUATE EDUCATION

Dr. Alex M. Burgess submitted the report of the Committee on Postgraduate Education, a copy of which had been submitted to each member of the House and which is made a part of the official minutes of this meeting.

It was moved that the report of the Committee be accepted. The motion was seconded and adopted.

Dr. Burgess requested that the House take action on the first recommendation relative to a committee to draft a tentative plan for staff organization including plans for routine patient care and an educational program at the new United States Veterans Hospital.

Extended debate on the question of whether the Postgraduate Education Committee or a new committee should undertake this task followed, and if a new committee, how it would be composed.

Dr. J. C. O'Connell moved that the Society have a new committee to be elected by the House of Delegates and to be representative of all the hospitals in the State, to serve as the committee to draft the plan for the staff organization for the veterans hospital in accordance with the recommendation from the Postgraduate Education Committee. The motion was seconded and adopted.

Dr. Mara moved that the Secretary communicate with the President of the staff of the various hospitals in the state requesting that each staff submit three names to the House of Delegates of physicians that it feels qualified to serve on the new veterans hospital committee. The motion was seconded.

After discussion Dr. Mara amended the motion that ten of these men so nominated should be elected by the House of Delegates to comprise the committee. The amended motion was seconded and adopted.

MEDICAL ECONOMICS COMMITTEE

Dr. William P. Davis, Chairman of the Committee on Medical Economics submitted a report in which the following recommendations were made:

1. It is recommended by this Committee that all fees for insurance examinations be increased.
2. It is suggested that the fee for an initial examination be at a minimum of $10.
3. Subsequent examinations should be consistent with the present office fee but with a minimum of $3.
4. E.K.G. and interpretation $15.
5. Special exams such as blood and sugar tolerance tests $10.

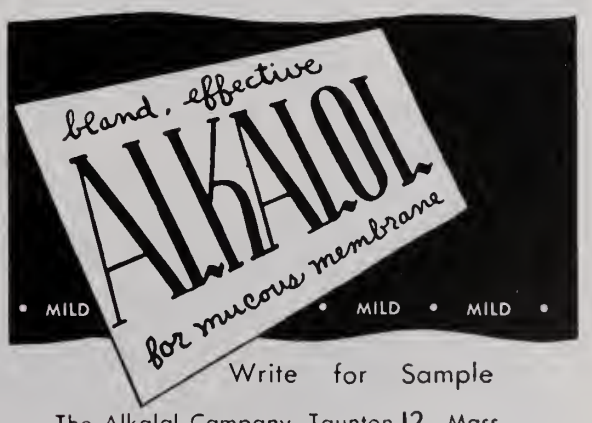
It was moved that the report of the Committee be accepted and that the recommendations incorporated therein be adopted. The motion was seconded and adopted.

It was moved that authority should be given to the Committee on Medical Economics to notify the various insurance companies and the members of the Society of the position of the Society relative to the fee changes proposed. The motion was seconded and adopted.

COMMITTEE ON SOCIAL WELFARE

Dr. Peter F. Harrington reported for the Committee on Social Welfare, making the recommendations as follows:

continued on page 67



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In manifest vitamin deficiencies it is inadvisable and impractical to rely primarily on dietary correction. The deprivation of essential nutrient factors usually has existed for many years, and it is important to give adequate treatment in order to restore health promptly. Pluraxin is especially designed for intensive vitamin therapy.

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Vitamin B_1 (thiamine)	15 mg.
Vitamin B_2 (riboflavin)	10 mg.
Vitamin B_6 (pyridoxine)	2 mg.
Nicotinamide	150 mg.
Calcium pantothenate	10 mg.
Vitamin C (ascorbic acid)	150 mg.
Vitamin D_2 (calciferol)	1,000 U.S.P. Units

Same formula ***with folic acid*** 5 mg. per capsule



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HOUSE OF DELEGATES MEETING

concluded from page 65

That the fees for surgical procedures performed outside the hospital on patients who are recipients of aid from the Department of Social Welfare be the same as those fees for similar procedures as are listed in the schedule of fees for the surgical plan adopted by the House of Delegates at its last meeting.

It was moved that the report of the Committee and the recommendation made by it be accepted and adopted. The motion was seconded and adopted.

MEDICAL DENTAL RELATIONS

Dr. Charles L. Farrell, Chairman of the Committee on Medical-Dental Relations, discussed the lengthy report, a copy of which had been submitted to each delegate and which is appended to and made a part of the official minutes of this meeting.

After discussion of the report it was moved that the House of Delegates accept the report and approve in principle the suggestions relative to medical-dental relations outlined in it. The motion was seconded and adopted.

PUBLICITY ON THE INDUSTRIAL HEALTH REPORT

Dr. Ruggles asked whether it was the desire of the House to publicize the action taken relative to the Workmen's Compensation recommendation. It was moved that the report of the Committee on Industrial Health be released to the press. The motion was seconded and adopted.

The meeting adjourned at 11:30.

Respectfully submitted,

MORGAN CUTTS, M.D.
Secretary

ROSTER CORRECTIONS

The following changes in addresses of members since the publication of the roster of Fellows in the September issue of the Journal have been reported:

Capwell, Remington P., 32 Reservoir Avenue, Providence 7	WI 2255
Sheridan, James J., (Pawtucket) 329 Broad Street, Valley Falls	PE 0233-W
Barrett, John T., 15 Everett Avenue, Providence 6	GA 2006
Trott, Raymond H., 219 Waterman Street, Providence 6	GA 1721
Nevitt, Francis W., 575 Pontiac Avenue, Cranston	HO 3500
Segall, Werner, 155 Angell Street, Providence 6	JA 1801
Smith, Orland F., (Pawtucket) 275 Angell Street, Providence 6	UN 1010
Charon, Ernest A., (Woonsocket) 105 Coyle Avenue, Pawtucket	BL 3164
Barrett, Harold S., 9621 Howard Avenue, Bethesda 14, Maryland	
MacDonald, William J., 56 Walnut Street, East Providence 14	
Kennedy, John A., (Woonsocket) 635 West 165th Street, New York 32	



Medical Secretaries

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DISTRICT SOCIETY MEETINGS

WOONSOCKET DISTRICT MEDICAL SOCIETY

The fall meeting of the Woonsocket District Medical Society was held at the St. James Hotel on the twenty-third of October. At the opening of the meeting the applications of Doctors Dominic P. Ferruci, Philip Sheridan and Alton Thomas were read and referred to the censors for action at the next meeting.

Officers for the 1947-48 year were elected as follows: Richard Dowling, President; Thomas Lalor, Vice President; Alfred E. King, Secretary; Paul Boucher, Treasurer; Joseph Reilly and Augustine Eddy, Delegates to the State Society; Euclide Tremblay and Joseph McKenna, Censors; Saul Wittes, Councillor; and George Keegan, Alternate Councillor.

With President Dowling in the chair, Dr. Charles Farrell of Pawtucket was introduced and there followed a discussion of the Surgical Plan as developed by the House of Delegates. The Society voted unanimously to support the plan as approved by the Rhode Island Medical Society.

Mr. John Farrell discussed chiropractic advertisements as they appear in the local newspaper and a committee was appointed to discuss them with the local publisher.

After adjournment of the meeting President Dowling appointed Henry Gauthier to act as the District Society representative on the Health Insurance Committee and he accepted the appointment.

Sandwiches and coffee were served at the conclusion of the meeting. Attendance, 24.

Respectfully submitted,

ALFRED E. KING, M.D.
Secretary

KENT COUNTY MEDICAL SOCIETY

An important meeting concerning the proposed Kent County Memorial Hospital was held the evening of November 12, 1947, at Dr. Peter Erinakes' office.

A quorum of the Board of Trustees, the Hospital advisor, Dr. Alan Craig, the hospital architect, Mr. Prout, representatives of the Kent County Dental Society and members of the Kent County Medical Society attended.

This meeting was called to order by Mr. Charles T. Algren, chairman of the Trustee Board, who presided throughout.

Mr. Prout, chief architect, presented the plans for a 75 bed, with emergency facilities for 90 beds, modern hospital. Medical, Surgical, Obstetric, Radiologic, Laboratory, Dental, Physiotherapy and Outpatient facilities are adequate and the plans have been drawn with the probable later increase in size and demand of the hospital in mind.

Dr. Alan Craig, hospital advisor, then discussed at length the care such an institution could be expected to provide, and indicated the proper allocation of beds to the different services concerned in relation to total bed capacity.

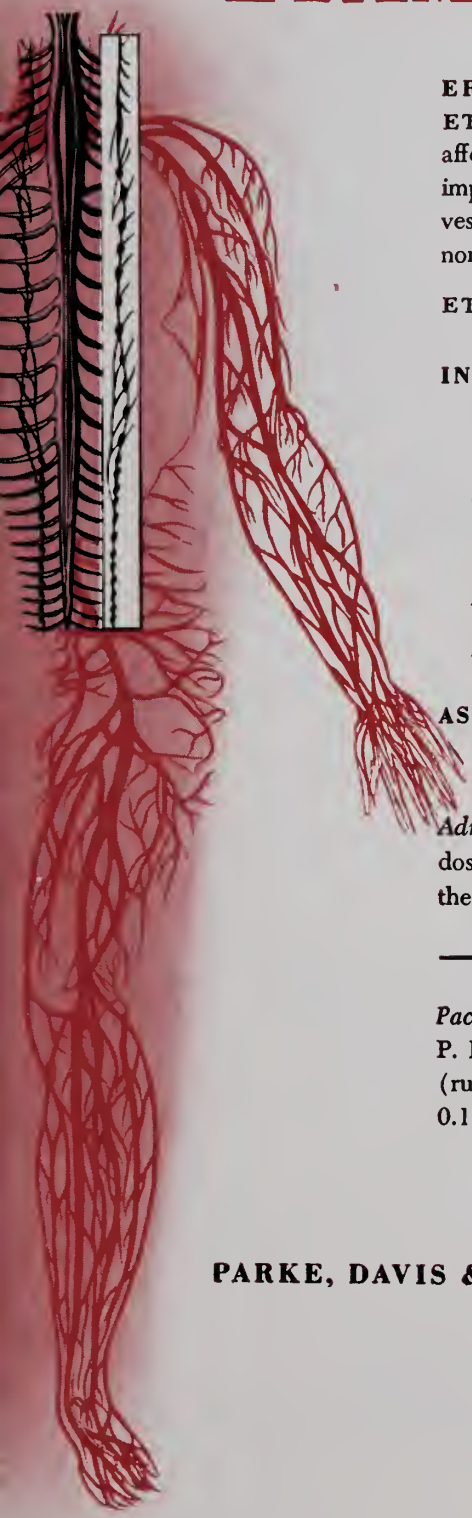
Mr. John C. B. Washburn, chairman of the Financial Committee, noted that considerable time has been given the preparation of this aspect of the project to date. A fund campaign will be initiated in February, 1948, and ended with a concerted drive during April and May of that year; appropriate publicity will attend this operation. Representatives of the corporation handling this financial phase of the program after careful survey of the area unhesitatingly predict favorable outcome. Mr. Washburn, concluding his remarks, urged everyone to keep the subject well stimulated in conversational contacts.

The Corporation attorney, Mr. George Rocke, then proposed a prepared amendment to the By-Laws which in effect included in the corporation, in addition to the Officers of the Kent County Medical Society, persons who for the time being shall hold the offices of Mayor or Council president of the city and towns of Warwick, West Warwick, Coventry, East and West Greenwich and at least twelve additional members to those heretofore elected by the original incorporators; the maximum number of members of the corporation shall not exceed two-hundred exclusive of the Officers of the Kent County Medical Society. This amendment was carried. Impressions of those in attendance seemed highly favorable; the Hospital plans were enthusiastically received and endorsed by Trustee, Medical and Dental Groups. A great deal of discussion was enjoined by each presentation and satisfactory conclusions reached in all instances.

continued on page 70

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KENT COUNTY MEDICAL SOCIETY

continued from page 68

The Medical Society President, Dr. Peter Erinakes in bringing the meeting to a close named committees for the annual Society Dinner to be held in December, and for the Nomination of Officers to serve the coming year. Drs. Mack and Taggart comprise the Dinner Committee; Drs. Davis, Merrill and Young the nominating group.

The meeting was adjourned at eleven-thirty.

Respectfully submitted,

FRANCIS D. LAMB, M.D.
Secretary

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, December 1, 1947. The meeting was called to order by President Guy W. Wells at 8:35 p.m.

The Secretary read a communication received from the Secretary of the State Medical Society relative to the actions taken by the Council and the House of Delegates of that body. He noted in particular the reports of the Committee on Medical Economics and the Committee on Social Welfare.

The Secretary reported that at a recent meeting of the Executive Committee the following action had been taken:

1. The President was empowered to call a meeting of the physicians of Cranston to discuss ways in which they may cooperate in solving some of their local medical problems.
2. The following slate of officers for 1948, in accordance with the By-Laws, was drafted for submission to the Association at the Annual Meeting on the first Monday in January. Counter nominations must be made in writing ten days prior to the annual meeting:

President	PHILIP BATCHELDER, M.D.
Vice President	GEORGE W. WATERMAN, M.D.
Secretary	DANIEL V. TROPPOLI, M.D.
Treasurer	J. MURRAY BEARDSLEY, M.D.
Executive Committee (2 members for 3 year terms)	GUY W. WELLS, M.D. HERMAN A. LAWSON, M.D.
Trustee of R. I. Medical Library	FRANK B. CUTTS, M.D.

Delegates to House of Delegates of R. I. Medical Society

Robert Baldridge, M.D.	Russell R. Hunt, M.D.
Philip Batchelder, M.D.	Albert H. Jackvony, M.D.
J. Murray Beardsley, M.D.	Walter S. Jones, M.D.
Alex M. Burgess, M.D.	Louis I. Kramer, M.D.
Peter Pineo Chase, M.D.	Herman A. Lawson, M.D.
B. Earl Clarke, M.D.	Edward A. McLaughlin, M.D.
Paul C. Cook, M.D.	John C. Myrick, M.D.
G. Edward Crane, M.D.	Michael J. O'Connor, M.D.
Frank B. Cutts, M.D.	Edwin B. O'Reilly, M.D.
William P. Davis, M.D.	Patrick I. O'Rourke, M.D.
Donald L. DeNyse, M.D.	Daniel V. Troppoli, M.D.
David Freedman, M.D.	George W. Waterman, M.D.
Peter F. Harrington, M.D.	Frederick A. Webster, M.D.
William A. Horan, M.D.	Guy W. Wells, M.D.

The report of the Executive Committee was received and placed on file.

The President made the following announcements:

That the Committee of Dr. Herbert G. Partridge and Dr. Pearl Williams has prepared and submitted to the Secretary for permanent file the Association's tribute to the late Dr. Jay Perkins. While the membership stood in silence the President read a brief prayer.

That more than 500 members of the Rhode Island Medical Society have signed as participating physicians for the prepaid surgical insurance program to start the first of the year. I am asked to call to your attention again that a list of the participating physicians will have to be published about the first of the New Year. Therefore, any members of this Association who have failed to sign the form, and who intend to, are requested to give the matter prompt attention.

Participating physician forms are available on the table in the rear of the auditorium, and can be signed and left here tonight.

The Secretary reported that the Executive Committee voted to recommend for active membership in the Association the following physicians:

Michael Di Maio, M.D.

Samuel C. McKinney, M.D.

Max B. Fershtman, M.D.

David G. Wright, M.D.

It was moved that these physicians be elected to membership. The motion was seconded and unanimously adopted.

continued on page 72

MASSAGE

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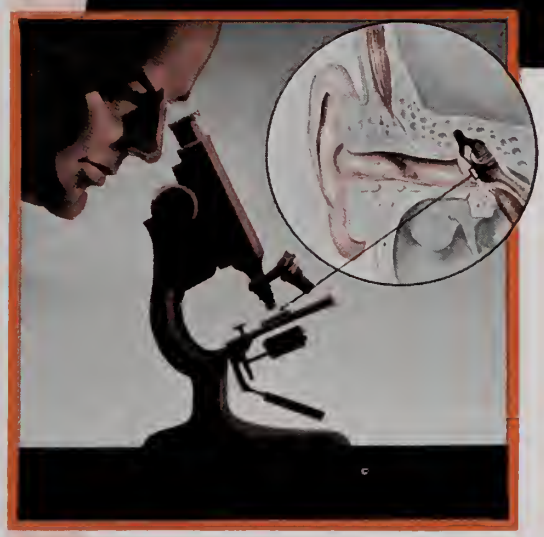
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PROVIDENCE MEDICAL ASSOCIATION

continued from page 70

Dr. Guy W. Wells, introduced as the first speaker of the evening, Dr. Michael Di Maio, Haffenreffer Research Fellow in Medical Sciences, Brown and Rhode Island Hospital, who spoke on "The Use of a Low Sodium Diet in Hypertension and Congestive Heart Failure."

Dr. Di Maio in his talk on low salt diet in hypertension stressed the fact that a low salt diet could be dangerous and that this treatment is the job of the internist.

Normal people tolerate and excrete sodium salt without difficulty. Cardiacs cannot excrete it as normals do and in this group the low salt diet is of value. Hypertensive cases with symptoms and cardiac failures are helped by this diet.

Formerly the chloride ion was stressed. Now sodium is considered the important ion.

Patients with hypertension and cardiac failure retain a large amount of sodium taken in the diet, due to decreased renal flow.

When water alone is given, salt is decreased and the kidneys are stimulated to excrete more water. The metabolism of Sodium is intimately bound up in the metabolism of potassium. Ingestion of large quantities of one decreases the other. The relatively high potassium content of this diet will help eliminate sodium.

The average hospital diet contains 6 gms. of salt and may hit 15 gms. The salt free diet at the hospital has 3 gms. of salt. This fails to influence blood pressure. It has to be less than 0.5 gm. of salt a day. Fluid intake is also important. With the former low fluid and low salt diets the results were neutralized. Therefore, no restriction of fluid is necessary even in severe anasarca. If nausea is present intravenous fluids must be given. 1500 to 2000 cc of water daily are well tolerated.

He then presented a diet with low sodium content with a menu for the week.

Dr. Wells introduced the second speaker of the evening, Dr. George Waterman, Chief of Staff, Department of Gynecology, Rhode Island Hospital, who spoke on, "Carcinoma of the Cervix Its Prophylaxis Early Diagnosis and Treatment."

Dr. Waterman in his paper on diagnosis of cancer of the cervix stated the three chief aims in view viz., prophylaxis, early diagnosis, and early treatment.

Cancer of the cervix usually starts at the junction of the columnar and squamous cells of the porta, and predominates in females who had children, resulting in chronic inflammation from the cervical glands of torn cervices. This stage of cervicitis has something to do with cancer development. He advocates cantery of the cervix after 1st delivery as a prophylaxis.





double deficiency

"Predisposed to Abortion" describes women who habitually abort because of ovarian hormonal deficiencies. Most spontaneous abortions are preceded by low estrogen and pregnandiol levels indicating that the corpus luteum or chorioplacental system is not producing enough estrogen and progesterone to maintain pregnancy.[1] Often in cases of this kind the woman can become a mother if Estrogen-Progesterone Solution is used to correct the DOUBLE DEFICIENCY. Estrogen-Progesterone is also useful in rapid treatment of secondary amenorrhea.[2] (Zondek technique.)

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1. Vaux, H. W., and Rakoff, A. E.: Am. J. Obst. & Gynec., 50:353, Oct. 1945.
2. Zondek, B.: J.A.M.A., 118:705, Feb. 28, 1942.

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Cancer of the cervix is not rapidly developing. If an effort is made to look for it, cancer in early stage can be found. Changes in the cervix can be noted and chronic cervicitis can be treated and this wards off cancer.

Lay education and detection clinics are an effort in the direction of early diagnosis. Cervical biopsy usually makes the diagnosis, but even the biopsy may miss the lesion.

The vaginal smear method of Papanicolaou is not a simple procedure. The time may come when a cytology laboratory is established to which doctors can send their smears. Exfoliated cancer cells are found in the smear and a diagnosis is made. Dr. Waterman showed statistics that proved that treatment with radium according to the Rhode Island Hospital technique was superior to surgery in long range cures.

The meeting adjourned at 10:50 p.m.

Respectfully submitted.

DANIEL V. TROPPOLI, M.D.
Secretary

PAWTUCKET MEDICAL ASSOCIATION

A regular monthly meeting of the Pawtucket Medical Association was held November 20, 1947, in the Nurses Auditorium of the Memorial Hospital. The meeting was called to order by the President, Dr. Earl Mara, at 9 p.m.

Dr. Nathan Sonkin was unanimously elected to membership after the Secretary reported his application had been approved by the Standing Committee. The application of Dr. Ernest J. Smith, Jr., was read and referred to the Standing Committee. The Secretary read a letter from the General Secretary of the Pawtucket and Central Falls Y.M.C.A. inviting an inspection by the Medical Association of a new Health Service Department. The letter also asked for an expression of the Medical Association regarding this venture. It was moved that the Association should refer this matter to the proper committee of the Rhode Island Medical Society to ascertain whether or not it involved an infringement of medical practice.

Dr. G. Raymond Fox discussed a preliminary report from the American College of Surgeons regarding a Cancer Detection Clinic at the Hospital. It was moved that the Association go on record as approving the Cancer Detection Clinic and also that the President appoint an advisory committee for the Clinic.

Dr. Earl Kelly, Councillor of the Association, gave a report on the recent meeting of the Council of the State Medical Society.

continued on page 78

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HOSPITAL ASSOCIATION OF RHODE ISLAND

ANNUAL MEETING OF HOSPITAL ASSOCIATION

The Annual Meeting of the Association was held at the Rhode Island Hospital at 3:00 P. M. on December 3rd.

The following slate of officers was elected unanimously:

President	Oliver G. Pratt
Vice-President	William E. Sleight
Treasurer	Norman Wigglesworth
Secretary	Francis C. Houghton
Trustee for 1 Year	Walter C. Harrington
Trustee for 3 Years	Mrs. Ellen B. Havens
	Dr. Harmon P. B. Jordan

An innovation at this Annual Meeting was the introduction of equipment demonstrations arranged by the Council on Hospital Planning and Plant Operation, of which John F. Latcham was Chairman. Three competitive makers of ice machines had their equipment set up and were each given an opportunity to demonstrate and to answer questions.

The following paragraphs are quotes from the report of the President, Oliver G. Pratt, who had just completed one year in this important office:

"Nationally I am sure that the voluntary hospitals attained added stature in the minds of national leaders and of the general public. I am sure that the American Hospital Association is now respected by many national associations, including The American Medical Association and the American College of Surgeons."

"On the State level I am also confident that we have increased in stature. This is perhaps due to the great needs of voluntary hospitals at this moment and the resultant activity in efforts to safeguard the future of voluntary hospitals. Because of the size and the acuteness of the problems we were facing in Rhode Island it seemed necessary to enlist the aid of the Trustees of hospitals to a much greater degree. It is interesting to note that this precedure has been followed in other states, notably Maryland, with marked success."

"Blue Cross has continued to work with hospitals and it was as a cooperative effort that the Presidents of each of the Hospitals of Rhode Island were able to meet with the Administrators at a luncheon. We were conscious of the fact that we, as paid officers of hospitals, did not have the standing before the legislature that would be inherent to Trustees of Hospitals and the Trustees in turn agreed that our problems were of adequate importance to warrant their concerted effort. I personally am very confident that we would not have been able to report a much improved arrangement for Workmen's Compensation as an accomplishment of the year unless we had first received the acceptance of the fact that the financial problems of the voluntary hospitals of Rhode Island were of such magnitude that concerted effort by Trustees was imperative."

"The fact that this Association, now fifteen years old, was incorporated under the laws of Rhode Island, is another milestone worthy of record."

"The Third New England Institute for Hospital Administrators held at Brown University in June was an important activity for this Association. It was conducted in such a manner as to command favorable comment by local educators and national hospital leaders."

"Another important activity was the nurse recruitment campaign which was sponsored by the Blue Cross and backed by this Association."

"Looking forward to the coming year I feel that we are faced with two major problems. First, the adequate solution of our problem of payment of care for the indigent which is again a problem of great magnitude that warrants the active interest and support of Hospital Trustees. The second problem for the future is our relationship with government, specifically the Department of Health in connection with the Hospital Construction Act and the need for completion of a hospital plan for Rhode Island."

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lunching on her noon-hour

Eating is merely a necessary waste of time for Miss Stenton. She oversleeps after late dates, sneaks out of the office for a bit of breakfast, gulps lunch so she can bargain-hunt on her noon-hour, wields a can-opener for a quick dinner in her apartment. Eventually she becomes one of the statistics in America's too high percentage of subclinical vitamin deficiency cases—that great group of persons who do not, will not or cannot maintain a balanced diet. For such cases, dietary reform may come first; then, as a wise precaution, many physicians are also prescribing easy-to-take Dayamin capsules, Abbott's multiple vitamins. Note the formula: six essential vitamins plus pyridoxine and pantothenic acid . . . all six vitamins in amounts which make Dayamin suitable either as a supplement or, in slightly larger doses, as a therapeutic agent. Your pharmacy has Dayamin capsules in bottles of 30, 100 and 250—also palatable Dayamin Liquid in 90-cc. and 1-pint bottles.
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15 Oct. 1947

Dr. Peter P. Chase
Editor, Rhode Island Medical Journal
Providence, R. I.

Dear Dr. Chase,

While at Rhode Island Hospital under Dr. Harris' direction I initiated a study of hips treated for fracture during an eight-year period since previous summation. This was begun in the last months of 1946 and most of the data were not finally brought together until July, 1947. It has taken something more than a month's concentrated work to assemble all the material as well as much over a period from time of beginning. I am sending it along for your judgment as to presentation, also copies to Dr. Harris and the Chief. I am only sorry not to have had another month to send in nothing but follow-ups by car. Complete mail inquiry program did not raise half the material available by a more personal survey.

Very extensive assistance was given by Mrs. Reed of the Social Service Dept. and voluntary assistants also the staff of the Record Room. I had hoped to send this along sooner but a couple of weeks fever and other distractions retarded me. Certain references should be included but it will be two or three months now before I shall be able to get to a medical library.

We still have a few lions around this country so if you should get lion hungry take a week end off. It is only 36 hrs. to Cairo and another 6 to Khartoum and then a few days by car and mule and they're waiting for you.

My best to such as might find it of interest,

Sincerely,
Edward B. Payne, M.D.

Editor's Note: See Page 48 for Doctor Payne's Article.

BOOK REVIEWS

DISEASES OF THE NOSE, THROAT AND EAR, by William Lincoln Ballenger, M.D., F.A.C.S., Howard Charles Ballenger, M.D., F.A.C.S., John Jacob Ballenger, B.S., M.D., Lea & Febiger, Publishers, Philadelphia, 1947, $12.50

I am impressed with the simple clarity of the text and the illustrations. The manner in which the schematic and other drawings and illustrations bring out detail, which too often is made confusing by words, makes this book superior to most other texts.

Anatomy, pathology and surgery of the ear, nose, throat and larynx are much easier to understand after reading Ballenger's "Diseases of the Nose, Throat and Ear."

It is a very comprehensive and detailed coverage of this subject.

Rudolph W. Pearson, M.D.

A TEXTBOOK OF MEDICINE, Edited by Russell L. Cecil, A.B., M.D., Sc.D., W. B. Saunders Company, Philadelphia, 1947, $12.00

A striking index of the recent rapid changes in medical thought and practice is afforded by the contrast of successive editions of a popular textbook of medicine. This latest edition, the seventh, of Cecil appears in what is a relatively short time since the third edition (1934) was this reviewer's medical school vade mecum. The value of the earlier volume has now been reduced to the purely sentimental, chiefly by the notable advances in the field of therapeutics. These include the antibiotics, the sulfonamides, the newer anticonvulsants, new protozocidal drugs, potent hormonal and nutritional substances, and a host of lesser syntheses and discoveries. The treatment sections are those, therefore, in which the greatest contrast is to be found.

Therapeutics, though it be the raison d'être and the apex of the structure of clinical medicine, should not be the only branch to observe for the evidences of medical progress. There has been a certain change in attitudes, and in emphasis, which is reflected in the new text. For example, though the pagination of the new edition has increased but slightly, diseases of allergy are allotted twice as much space, the section on endocrinology has similarly increased, and, in keeping with the times, an entirely new article, psychosomatic medicine, has appeared. Dipping into the two editions at random, one notes that sarcoidosis which was ignored in the earlier edition now has an excellent three page description. It is ironical that the cycle of recognition and treatment of vitamin deficiencies just being evolved in the earlier edition, has

continued on page 78





comprehensive protection with a **SINGLE INJECTION**

The use of Diphtheria and Tetanus Toxoids, Alum Precipitated, and Pertussis Vaccine Combined, has largely replaced the practice of repeated injections for immunization against specific infections. These combined antigens produce an immune titer equal to or greater than that effected by the antigen injected individually. The *simultaneous triple defense* provided by this comprehensive treatment greatly reduces the incidence of contagion in a community and makes possible a reduction of infant mortality rate.

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48 South Main Street

. . . As published in the PROVIDENCE DAILY JOURNAL, April 3, 1848

BOOK REVIEWS

concluded from page 76

reached a point where the present volume must needs include an article on hypervitaminosis.

Cecil's textbook differs from most of the other popular texts of medicine in that instead of a single editor being responsible for large sections of the work, several contributors have written, at the most, a few articles apiece. This has the advantage of ensuring an accuracy of detail probably not otherwise obtainable, but does seem to lead in places to overspecialization. Thus, hemifacial atrophy, hemifacial hypertrophy, and hemifacial spasm enjoy not only individual treatises, but different contributors as well. Perhaps, too, the personal touch of a single editor, as of an Osler, has been sacrificed for encyclopaedic exactness.

The list of contributors comprises a Who's Who of American Medicine and includes not merely distinguished internists, but outstanding surgeons, psychiatrists, and pediatricians—a demonstration of the necessary catholicism of what is termed internal medicine. It is probably the most complete survey of modern medicine available in a single volume. Textually it has always been highly readable, and in its new format of double columns and sharp clear print, its readibility has been literally increased. Though apparently designed for the medical student, even an experienced practitioner may well use the volume for quick reference, or refreshing casual browsing.

Irving A. Beck, M.D.

PAWTUCKET MEDICAL ASSOCIATION

concluded from page 73

The speaker of the evening was Dr. Walter Durkin, of Providence, whose topic was "Surgery in Potentially and Actually Infected Obstetrical Cases." Dr. Durkin presented and discussed two films on extra peritoneol Caesarian Section. A film depicting the use of sterile absorbable oxized cellulose (oxycel) was shown afterwards.

Twenty members attended. Refreshments were served.

Respectfully submitted,
K. W. Hennessey, M.D.
Secretary

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HARLAN P. ABBOTT, M.D., retired Providence surgeon and ear, nose and throat specialist, died at the Rhode Island Hospital on February 3, 1947, in his 87th year, after a long illness. He was born July 10, 1860, in Antrim, New Hampshire. He was graduated from Phillips Exeter Academy and received an A.B. Degree from Brown University in 1885. He was graduated from Harvard Medical School in 1889 and in the same year the Degree of A.M. was conferred upon him by Brown University. He served an internship at the Rhode Island Hospital from 1889 to 1891 and was a member of the visiting staff from 1891 to 1920. From 1908 until his retirement he was chief surgeon of the ear, nose and throat department of the Rhode Island Hospital. At the time of his death he was consulting surgeon at the Rhode Island and Pawtucket Memorial Hospitals. He was a member of the Providence Medical Association, a Fellow of the Rhode Island Medical Society and the American College of Surgeons, a member of the American Board of Otolaryngology, and of the Medical Improvement Club of Providence. He had served as past president of the Rhode Island Ophthalmological and Otological Society. During the Spanish-American war he was an acting assistant Surgeon of the Army.

BERTRAM H. BUXTON, M.D., died in Providence on February 10, 1947, at the age of 63. Dr. Buxton had retired last year as chief of the Medical Staff of the Providence Lying-In Hospital. He was born in Worcester, Massachusetts, on June 11, 1883, and he was graduated from Classical High School in 1900 and from Brown University in 1904. He graduated from Harvard Medical School in 1908 with the second highest honors in a large class. He interned at Rhode Island Hospital from 1908 to 1910 and in the following two years served as Assistant Superintendent of that Hospital. In 1912 he interned at the Boston Lying-In Hospital and later in the year he returned to the Rhode Island Hospital outpatient department. He served in the first World War and was awarded the Purple Heart and the Silver Star with Palm for gallantry in action. In 1919 he became Assistant Surgeon in Gynecology in the Rhode Island Hospital and subsequently was promoted to department surgeon. From 1919 to 1927 he was assistant visiting obstetrician in the Lying-In Hospital and during the next eight years he served as visiting obstetrician. During the same period he was chief of staff of the gynecology department of the Charles V. Chapin Hospital and in 1935 he was appointed chief of staff at the Lying-In Hospital. Dr. Buxton was a former President of the New England Gynecology and Obstetric Society and a Fellow of the Boston Obstetrical Society and the American College of Surgeons. He was a member of the American Board of Obstetrics and Gynecology, and the American, Rhode Island and Providence Medical Associations. He was one of only two Rhode Island members of the American Society of Obstetrics, Gynecology and Abdominal Surgery.

SALVATORE CASTALLO, M.D., was born in Prata Sannita, Italy, May 18, 1871. After attending the public schools in his native town he entered Giordano Bruno College, in Maddaloni, Italy. After completing his studies there, he enrolled in 1890 in the Royal University of Naples, graduating on July 23, 1896, with the degree of Doctor of Medicine and Surgery. Dr. Castallo began practicing in Providence in March, 1901. He maintained an office for many years at 306 Broadway and more recently conducted his profession from his Blackstone Boulevard home. He was a member of the Providence Medical Association, the Rhode Island Medical Society and the American Medical Association. Dr. Castallo died on March 18, 1947, after an illness of several months.

GEORGE V. COLEMAN, M.D., chief surgeon of the Providence Police and Fire Departments for more than twelve years and a well-known general practitioner in the city, died on December 10, 1947. Dr. Coleman was born in Providence on March 31, 1891. He was graduated from Classical High School in 1911, received his Bachelor's degree from Holy Cross College in 1915, and his doctorate from the Harvard Medical School in 1919. He interned at Rhode Island Hospital from 1920 to 1922. He was on the staff at St. Joseph's Hospital, Homeopathic Hospital and the Lying-In Hospital. In April, 1935, he succeeded Dr. Clifford H. Griffin as police and fire surgeon. He was a member of the Providence

Medical Association, the Rhode Island Medical Society and the American Medical Association.

HAMPARTZUM S. GULESSERIAN, M.D., a practicing physician in the Smith Hill section of Providence for twenty-two years, died on January 3, 1947. Dr. Gulesserian was born in Harpout, Armenia, on May 11, 1883, and he received his early educational training in the district schools of Housenig. In the year 1906 he was graduated from Euphrates College in Turkey. After teaching in Armenian colleges for two years he enrolled in the University of Beyrouth (Syria) Medical School from which he graduated in 1912 with the degree of medicine. During the years 1912-1914 Dr. Gulesserian practiced medicine in Harpout, while at the same time teaching physiology and hygiene at Euphrates College. During World War I he saw service in the Turkish Army as a Medical Officer. In 1924 Dr. Gulesserian brought his family to the United States. He became a member of the Providence Medical Association and the Rhode Island Medical Society in February, 1940.

WILLIAM A. McLAUGHLIN, M.D., a practicing physician in Providence for more than half a century died on December 6, 1947, in his 79th year, after a long illness. Dr. McLaughlin established a practice in this city in 1896 and he was still active at the time of his death. For over 25 years he was a staff member at St. Joseph's Hospital. He was born in Providence on April 30, 1869. After attending Christian Brothers High School, now La Salle Academy, he studied at the Medical School of Dartmouth College and was graduated in 1894. The following two years he did postgraduate work at the Sloane Maternity Hospital and Bellevue Hospital in New York.

JAY PERKINS, M.D., a physician well-known for his crusade against tuberculosis, died on October 18, 1947, at the Rhode Island Hospital. Dr. Perkins was born in South Penobscot, Maine, on October 15, 1864. He graduated from the Normal School, Castine, Maine, in 1884, and from Coburn Classical Institute in Waterville, Maine, in 1887. He entered Colby College but left at the end of his second year to enter Harvard Medical School from where he was graduated in 1891. He served as intern in the Rhode Island Hospital from 1891 to 1893 and in the Boston Lying-In Hospital for a six months' term in 1893. Dr. Perkins was pathologist to the Rhode Island Hospital from 1894 to 1900. He was Medical Examiner in Providence from 1896 to 1914. He organized the Tuberculosis Clinic in the Rhode Island Hospital in 1900, and also the Providence Tuberculosis League, and was first President of the latter, serving until 1938 when he resigned and was elected President Emeritus. As a direct result of his efforts the State Sanatorium was opened in September, 1901. He was attending physician on the staff there for two years. Dr. Perkins was chairman of the Committee for the Relief and Control of Tuberculosis and was a director of the Rhode Island Tuberculosis Association. He was a member of the American Climatological and Clinical Society, the American Medical Association, the Rhode Island Medical Society, serving as Secretary from 1912 to 1916 and the Providence Medical Association. He was consultant at the Rhode Island and the Charles V. Chapin Hospitals.

VICTOR P. da CUNHA REGO, M.D., was born in Lisbon, Portugal, in 1886. He graduated in 1915, Faculdade de Medicina (Faculty of Medicine), University of Lisbon, Portugal, and upon his graduation became assistant to the Professor of Pathology in that school. He spent two years in the interior of Portuguese West Africa where he was physician for the Angola Diamond Company, after which he sailed to India. Upon his return to Portugal from India he travelled to the United States, serving several times as ship's physician on a Portuguese passenger ship. After a few of these trips he was persuaded by friends to remain in Providence and to enter private practice here. He served faithfully and efficiently a large proportion of Portuguese American as well as native citizens and was highly regarded by all who knew him. Dr. Rego died at his home in Lisbon, Portugal, on June 22, 1947.

ALLEN A. WEEDEN, M.D., died at the Woonsocket Hospital on January 27, 1947. He was born in Brooklyn, New York, and he was educated in the Providence Public Schools. He was graduated from Tufts College Medical School in 1905. From 1905-1906 he was an intern at the Woonsocket Hospital and was on the staff at that hospital from 1906 until his death. Dr. Weeden was in charge of Physical Therapy. He served as Medical Inspector in the North Smithfield Schools, and he was a member of the Rhode Island Medical Society, and President of the Woonsocket District Medical Society in 1922.

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INDEX OF ADVERTISERS

	PAGE
Abbott Laboratories	75
Alkalol Company	65
American Meat Institute	79
Ames Company, Inc.	59
E. P. Anthony, Inc.	43
Ayerst, McKenna & Harrison	5
Ar-Ex Cosmetics, Inc.	67
Ba-Bee Formula Service	6
B. & J. Apparatus, Inc.	50
Baybank Pharmaceuticals, Inc.	1
Bayview Convalescent Home	50
Blanding and Blanding	14
J. E. Brennan & Company	59
George A. Breon and Company	72
Joseph Brown Company	59
Buffington's, Inc.	53
Burroughs Wellcome & Co. (USA) Inc.	8
Butterfield Drug Stores	6
Camel	60
S. H. Camp Company	55
Ciba Pharmaceutical Products, Inc.	51, 63
Curran and Burton	6
Doho Chemical Corporation	71
Edgewood School	67
J. E. Hanger, Inc.	6
Hillcrest, Inc.	6
H. P. Hood & Sons	4
Langlais Health Institute	70
Eli Lilly & Company	Insert between 14-15
S. E. Massengill Company	11
Mead Johnson & Company	Back cover
Medical Milk Commission	73
A. B. Munroe Dairy	54
Mutual Benefit Health and Accident Association	84
McCaffrey, Inc.	64
Narragansett Brewing Company	Inside back cover
National Drug Company	77
Neland Pharmaceutical, Inc.	6
Nutrition Research Laboratories	12-13
Parke, Davis & Co.	69
Philip Morris & Company	2
Physicians Directory	82, 83
Rexall Drug Company	10
Rhode Island Limb Company	78
Schering Corporation	47
G. D. Searle & Company	45
Sharp & Dohme, Inc.	57
Smith-Holden, Inc.	Inside front cover
Smith, Kline & French Laboratories	3
E. R. Squibb & Son	9
Strand Optical Company	74
Tilden-Thurber	46
Winthrop-Stearns, Inc.	66
White Laboratories	Insert between 6-7

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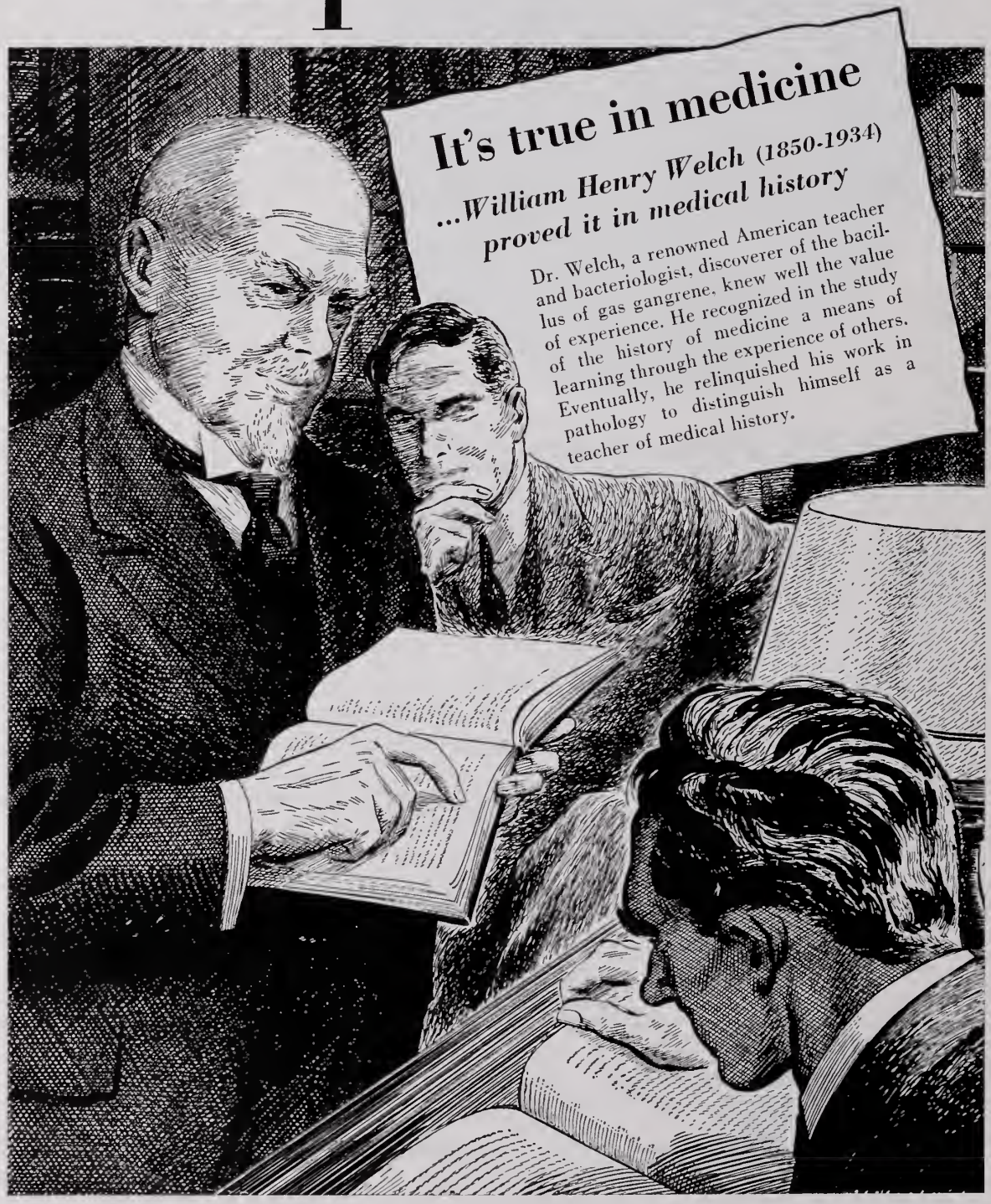
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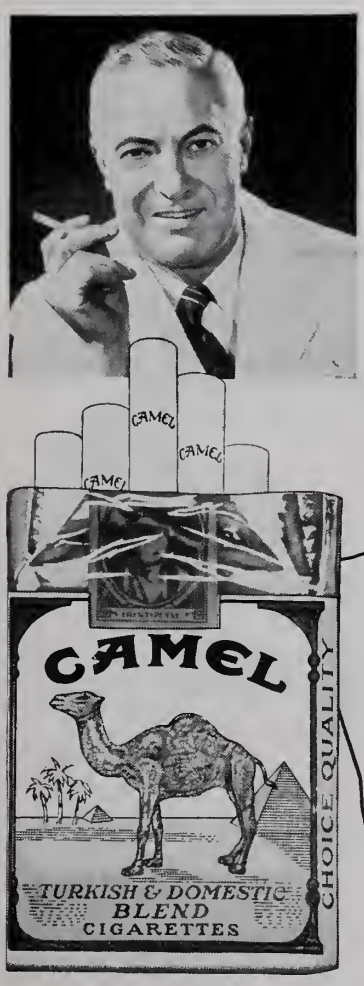
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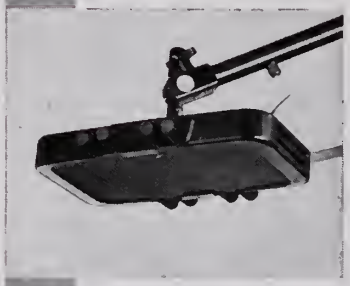
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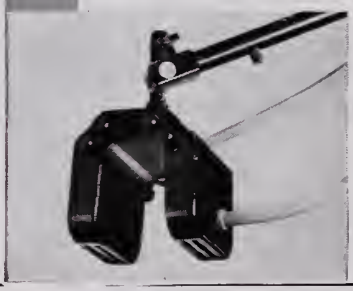
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Vol. XXXI, No. 2 February, 1948

TABLE OF CONTENTS

PAGE

Pneumococcic Lobar Pneumonia,
A Review of Cases at R. I. Hospital, 1945-1947, *Robert V. Lewis,* M.D. 99
Cholesterol Tolerance, *Frederic J. Burns,* M.D. 103
Wilms Tumor, Report of Two Cases
in the Same Family, *Mihran A. Chapian,* M.D. 105
The Pattern was Established, Presidential Address, *Guy W. Wells,* M.D. 107
Group Medical Practice, *Frederick T. Hill,* M.D. 114
Eighth Annual Congress on Industrial Health, Report of Delegate 134

EDITORIALS

The PMA Centenary 110
Quantity versus Quality 111
An Excursion Among the Eponyms 112

DEPARTMENTS

House of Delegates, Report of Meeting of January 21, 1948 120
Newport Medical Society, Report of Meeting 143
Pawtucket Medical Association, Report of Meeting 144
Providence Medical Association,
Report of 101st Annual Meeting 140
Annual Reports, 1947 146
Rhode Island Medical Examiners System, Report of Joint Committee
of R. I. Medical Society and R. I. Bar Association 126
Workmen's Compensation Law, Report of Industrial Health Committee 130

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Charles J. Marshall, New York Journal of Medicine, Vol. 34, Aug. 15, 1934

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*A Clinical Study of 180 Cases of Arthritis—Magnuson, P.B., McElvenny, R.T., and Logan, C.E.—J. Michigan State Med Soc 46.71 (January) 1947

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A 15 x 12 reproduction of this Edward Wilson illustration, suitable for framing, is available upon request.

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PNEUMOCOCCIC LOBAR PNEUMONIA

A Review of Cases in Rhode Island Hospital, 1945-1947

ROBERT V. LEWIS, M.D.

The Author. *Robert V. Lewis, M.D., of Providence. Haffenreffer Research Fellow in Medicine, Rhode Island Hospital.*

Introduction

Lobar Pneumonia has been the subject of extensive and intensive reviews in the past. Many of the factors which affect the natural history of the disease have been minimized in importance by the use of the effective therapeutic agents now at hand. This report is an attempt to re-evaluate, under the present regime of treatment, those factors in the disease which were so important in the past. The factors considered are the type organism, the character of the patient, the white cell response, the time of onset of therapy, and the types and amounts of therapy. The older reviews of pneumonia, especially that of Reimann[1] and the still older reviews typified by that of Norris[2], have been used for comparison. Patients arriving at Rhode Island Hospital are often neglected patients. Many represent therapeutic failures. These considerations should not be overlooked when viewing the following statistics.

Method

All cases of Lobar Pneumonia admitted to the Rhode Island Hospital between 1 January 1945 and 1 February 1947 were included in this review, except when a causative organism other than pneumococcus was isolated. There were only twelve cases, in over two hundred studied, which fell into the latter classification. Those cases where pneumonia was made as a second diagnosis were included in the series, but omitted from sections of the report where the effect of the first diagnosis would be such as to obscure the true nature of the pneumonia.

Results

MATERIAL:

One hundred and ninety-seven patients are included in the study. Approximately 75% of these are adults and the remainder children. The breakdown of the total group is shown in *Table No. 1.*

SEX AND AGE INCIDENCE:

Seventy per cent of all Lobar Pneumonia seen in Rhode Island Hospital, during the period stud-

Breakdown of Cases

ADULTS	
Uncomplicated	93
With Pleural Effusion	11
With Suspected Pleural Effusion (Undiagnosed)	12
Empyema	2
Pneumococcic Meningitis	1
Pneumonia as Second Diagnosis	17
Dead 24 Hours	10
Dead 24 Hours Plus	8
	154
CHILDREN	
Uncomplicated	41
With Pleural Effusion	0
With Suspected Pleural Effusion (Undiagnosed)	1
Empyema	0
Pneumonia as Second Diagnosis	0
Dead 24 Hours	1
Dead 24 Hours Plus	0
	43
	197

TABLE I

continued on next page

ied, occurred in males. Throughout the literature this sex ratio appears with constancy.[1,2,3] In the old literature it was generally considered that this sex incidence was due to the greater exposure of men than woman.[2] Reimann[1] makes the observation which is confirmed by this report that such reasoning does not explain the constancy of this ratio during the first year of age. The percentage of males in the pneumonia cases under one year of age in Rhode Island Hospital during 1945-6, was 75% compared with the 70% average for all ages.

LOBES INVOLVED:

The frequency with which each of the five lobes of the lungs is involved in Lobar Pneumonia in this Rhode Island Hospital series, reveals the following order: left lower lobe, right upper lobe, right lower lobe, left upper lobe, right midlobe. The same order held for children. The right lung was involved one and one-half times as often as the left. Twelve per cent of the cases observed had two or more lobes involved. The order of incidence of lobes involved in this series agrees with larger series except in one instance. In this Rhode Island Hospital series, the right upper lobe takes precedence of the right lower lobe, whereas the reverse is seen more often according to the literature.[1]

ORGANISMS ISOLATED:

The identification of organisms has become of less importance and more difficult since the advent of antibiotics. Of the two hundred cases admitted, pneumococci were identified in fifty. In 40% of the fifty cases in which organisms were isolated, the identification was not carried beyond the four typing mixtures. This was due to lack of type specific typing serum. In general the types observed in this series compare with the types observed in the literature. Type 1, which is most frequently encountered and usually accounts for about 27% of all pneumonia, occurred in 24% of the cases typed.

WHITE COUNT:

It is agreed that the leukocyte count is elevated in the early course of Lobar Pneumonia. It is a clinical impression that low white counts have a bad prognosis, although there are marked individual differences. Some observations on the behavior of white counts have been made in this series of cases. In those cases where afebrilia occurred in the second and third day, no cases with a white count below 12,000 were encountered, only one case in twenty of these cases had a white count below 14,000. By contrast three cases out of sixteen total cases in the next higher group with four days

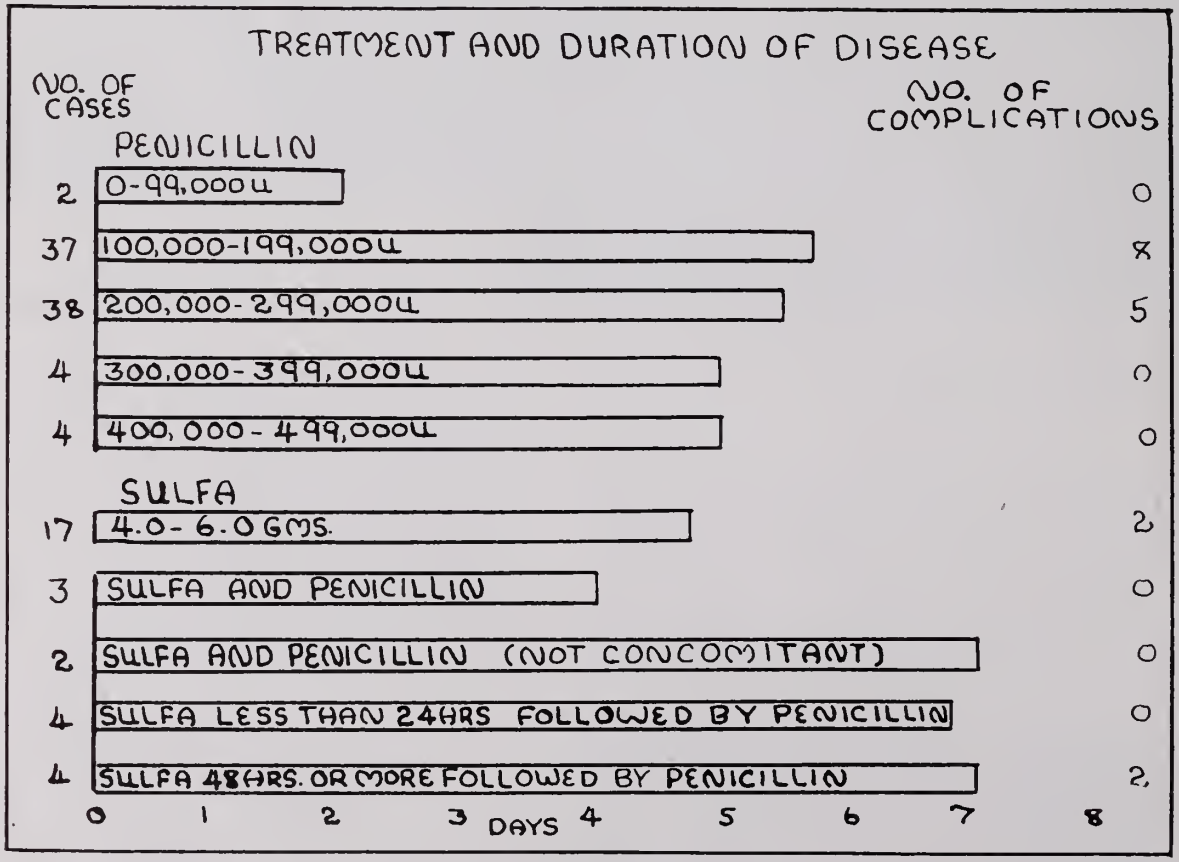


FIGURE 1

hospitalization, showed a white count below 10,000. Those cases with a 2-5 day hospitalization in contrast to patients with a 6-9 day hospitalization showed a higher initial white count which dropped sharply and rapidly following treatment. The same behavior of the white count was noted in the children's series.

TREATMENT:

Penicillin became increasingly more available to the civilian population in Providence during '45 and '46. The majority of cases were treated by penicillin in varying dosages. A not insignificant number were treated by sulfa drugs alone. A compilation of the data pertinent to treatment is listed on *Table No. 2* and graphically portrayed in *Figure No. 1.* The results in children and adults appear comparable in all respects. There appears to be very little difference between those patients treated with 1-200,000 units per day and those treated with 2-300,000. The differences shown by those treated with less than 100,000 units are probably due to the mildness of the disease and early therapy in those two cases. In the eight cases treated with over 300,000 units per day, the average number of days to afebrilia is less. The absence of any complication whatsoever in this group is worthy of much attention. The sensitivity of the pneumococcus IN VITRO is usually much less than 0.5 units per c.c. Such a concentration is obtained IN VIVO by 500,000 units of penicillin intramuscularly per day. This then is the theoretical maximum daily dosage required. That lesser dosages are effective as seen in this study indicates that the pneumococcus is usually much more sensitive and requires less than the maximal. This is confirmed by IN VITRO studies.

Treatment Effects

(ADULTS ONLY)

Per Diem	# Cases	Ave. # Days to Afebrilia	# Complications*
A. PENICILLIN (ALONE)			
0 — 99,000	2	2	0
100,000 — 199,000	37	5¾	8
200,000 — 299,000	38	5½	5
300,000 — 399,000	4	5	0
400,000 — 499,000	4	5	0
B. SULFA (ALONE)			
4.0 — 6.0 grams	17	4¾	2
C. PENICILLIN AND SULFA			
Both Adequate Concomitantly	3	4	0
75% of Treatment Sulfa 25% Penicillin	2	7	0
Sulfa Less Than 24 Hours After Admission	4	6¾	0
Sulfa 48 Hours Followed by Penicillin	4	7	2

* Complications include empyema, pleural effusion, poor resolution, death after 72 hours hospitalization.

TABLE 2

In comparing the effects of sulfa drugs alone with penicillin it is seen that sulfa compares well with penicillin except for complications of the disease. The danger of sulfonamides, especially in the elderly patients, has been stressed by Burgess, Wing, Kramer, and Bowman.[3]

In those cases where penicillin and sulfa were used together the results need explanation. Where penicillin and sulfa were both used adequately and simultaneously from the start excellent results were obtained, the number of days hospitalized were few and complications absent. In the other cases where penicillin and sulfa were not used simultaneously there is the factor of unsuccessful therapy requiring a shift from one drug to the other.

In general high doses of penicillin, that is, over 300,000 units of penicillin and sulfa in adequate doses, given simultaneously, all other factors being equal are the best treatments in that the hospitalization is short and complications are minimal.

LENGTH OF TREATMENT:

In this series the absence of fever finally and permanently was taken as the criteria of cure. In considering the distribution of cases to twenty-four hours afebrilia it is noted that the mode occurred in five days. Hospitalization to afebrilia without complication occurred between 2-9 days. In most cases over nine days there was complication or a suspicion of the same. Norris, in 1913, collected a series of approximately 2,000 cases and described the duration of Lobar Pneumonia, Reimann, in 1938, did the same with 873 untreated cases. Penicillin and sulfa have reduced the natural duration of the disease between two and three days.

DELAY IN TREATMENT:

It is a truism to state that delays in treatment in medicine affect the course of disease. The mode of the uncomplicated cases occurs with a two-day history of the disease prior to hospitalization and treatment. The average number of days prior to admission in uncomplicated cases is 3½ days. Contrasting this with those cases in which complications occurred, the mode occurred on the seventh day and the bulk of cases were admitted after the fourth day of disease. There is overlapping in both groups. Many cases admitted after the fourth day of disease may represent therapeutic failures by local physicians. Nevertheless, the fact remains, that considering hospital admissions only,

continued on next page

the patient who reveals a history of three or under three days' duration has a much better outlook than a patient who gives a history in excess of 3½ days. The antibiotic cannot overcome the disadvantage placed upon it by the delay in its early institution. The length of history prior to admission affects the probabilities of complications, and the number of days of required therapy. *(Table No. 3, Fig. No. 2)* After the fourth day further delay more markedly affects the subsequent course of the disease. The stage of gray hepatization occurs about the fifth day and data indicate that antibiotics administered after the fourth day may have difficulty in reaching the organisms because of decreased blood supply to the area. M. Cutts, Gormly, and Burgess[4] demonstrated the same unfavorable effect of delay in treatment in relation to serum and sulfapyridine therapy. There is one factor in the nature of the disease which must not be overlooked in considering the effect of delay in treatment on the course of disease. This is the observation of Norris in 1913, namely, that the nature of the onset affects markedly the outcome of the disease. That is, those cases which have an abrupt beginning have an early and successful outcome. It seems reasonable, therefore, to consider that the severity of the initial attack will determine the promptness with which the patient consults his physician. When the attack is severe, which in itself promises a good outcome, the patient is seen early and receives early therapy.

Treatment Delay and Disease Duration

No. of Hospital Days to Afebrilia		Average No. of Days to Admission	No. of Cases
2	Uncomplicated	2 (1⅔)	2
3	"	3 (2Ⅸ 14)	15
4	"	3	17
5	"	3 (2Ⅸ 16)	17
6	"	3	14
7	"	4 (3Ⅷ 13)	13
8	"	4	7
9	"	4	3
14	Pleural Effusion	5	11
14	Suspected Pleural Effusion	5	12
30	Empyema	8	2

TABLE 3

SUMMARY AND CONCLUSIONS:

1. The constants which have been observed in the past in Lobar Pneumonia were again observed in this review. Namely, an incidence of seven males to three females, progressive increase in morbidity in ascending age groups, the Winter and Spring seasonal incidence, more frequent involvement of the right lung, and the preponderance of types 1-3 pneumococci as causative organisms.

2. The length of the disease and complications are directly related to the duration of the disease prior to treatment.

3. Penicillin and the sulfa drugs have reduced the duration of the natural history of Lobar Pneu-

continued on page 109

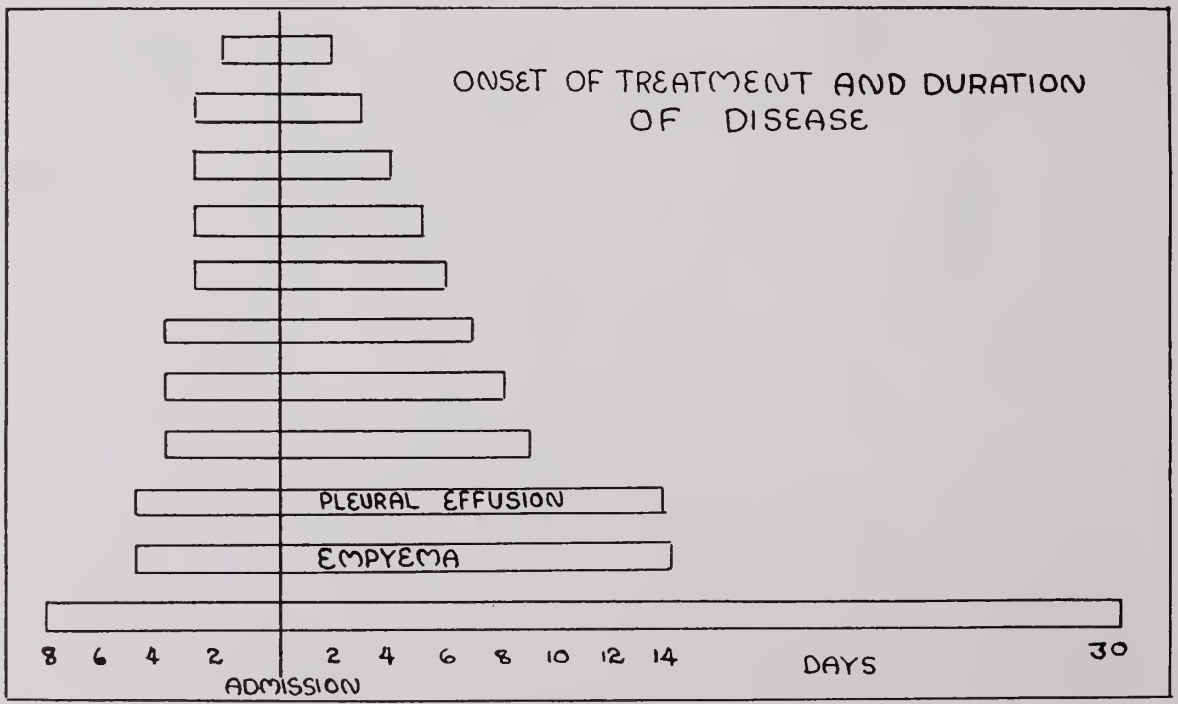


FIGURE 2

CHOLESTEROL TOLERANCE

FREDERIC J. BURNS, M.D.

The Author: *Frederic J. Burns, M.D., Visiting Physician, St. Joseph's Hospital, Providence.*

THE RECOGNITION of cholesterol deposits in the coronary arteries has long been known and, in recent times, has been widely investigated. In fact, various forms of investigations are being attempted. Primarily, this paper will try to show the possibility of an individual tolerance to cholesterol intake. Before such a theory can be accepted, however, a very extensive and comprehensive study of the entire problem must be completed. Much has been done, to date, but finality is lacking and may be long in coming.

The difficulties in estimating the cholesterol in the blood are such that a routine laboratory test will not give satisfactory and consistent results. It is most important that one of the accepted methods be used. In the cases reported in this study, a modification of the Bloor's test was employed throughout, and always the work was done by the same laboratory worker.

It is now generally accepted that the usual findings in those who have a coronary occlusion is an elevated cholesterol. This condition is noted even in individuals who present no other factors that would *per se* raise the cholesterol level. It has been observed, also, that the abnormal cholesterol can be lowered by diet. Substantial confirmation of this fact has recently been made by authorities in medical centers where this problem holds much interest. This process of reduction of the cholesterol by diet is a relatively slow one, but it is effective. In Figure No. 1 five such cases are shown, two of which were reported in a previous paper. All of these individuals, as others, on a similar diet, do not complain severely about food restriction. These patients, too, have received no medication. Diet alone has produced the desired effect. Two other patients with decreased metabolic rates, with high cholesterols, and with clinical findings of hypo-thyroidism showed a noticeable decrease in their levels when the diet was used in conjunction with oral thyroid extract.

This tendency towards a lowering in the cholesterol level as a result of dieting is now meeting with a more widespread acceptance among those

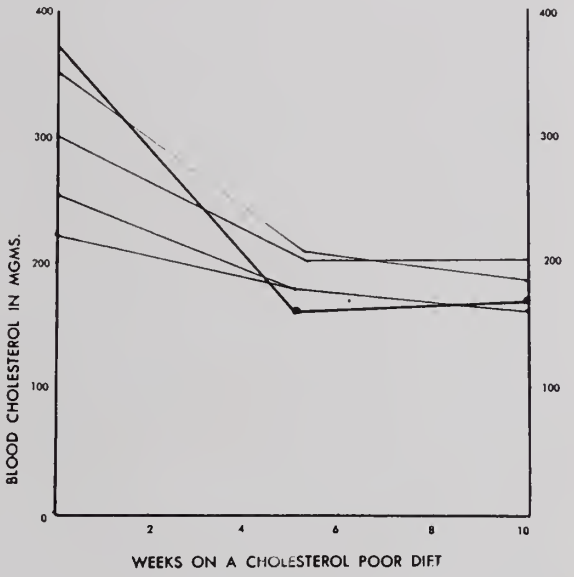


FIGURE 1

doing like investigations. Moreover, it has led to a whole series of unanswered questions.

One problem with great clinical importance which has developed from this study is the possibility of effecting a disappearance of the atheromata by a lowering of the blood cholesterol. From the microscopic pictures of atheromata, it does not now seem that such a result is attainable. In fact, the very nature of their composition seems to make a reabsorption practically impossible. A personal experience with two patients out of a group gives some credence to this opinion. These two persons had successfully lowered their elevated blood cholesterol, one for twelve weeks, the other for fifteen weeks, when death suddenly occurred from coronary thrombosis. This was at a time when neither of them had been under any undue strain. One had experienced an occlusion previously, while the second had diabetes that for many months had been under adequate control by diet and insulin. Possibly the period of twelve or fifteen weeks was not sufficient time to decrease the deposited cholesterol. But it is more probable that, once deposited, it cannot be eliminated. On this question, however, further

continued on next page

investigations must be accomplished before anything definite can be stated.

Another problem of tremendous importance is that of personal intolerance of cholesterol intake. This paper is but an initial attempt to show that individual factors must be considered in the specific case. Ten carefully selected patients were used to estimate tolerance and the findings give some indication of the part that this particular phase of the problem may play in the prophylactic approach in the treatment of some vascular diseases. These ten individuals were selected because no physical abnormalities were present. Of special interest was the exclusion of anyone with even the slightest suggestion of glandular disturbance, while persons with excess fatty tissue were considered unsuitable. The reason for omitting this latter group becomes clear when it is realized that with adiposity there is a general tendency for an elevation of the cholesterol. The age group of these ten varied from eighteen to fifty-four years with a predominance in the early forties. The main factor determining the choice of each one was the excessively high cholesterol intake, and on each a fasting blood cholesterol was done. When the possibility of lowering the cholesterol by diet is accepted, it seems quite reasonable that ten such individuals on a high cholesterol diet would reveal elevations. As seen in Figure No. 2, however, only one of these showed any increase. Of course, ten is much too small a number from which to obtain a percentage estimation, but it appears to the writer that the majority of this group have demonstrated some form of tolerance to cholesterol intake. At the moment, I have no suggestion that this tolerance, if it be such, is related to excretion, or to endocrine activity.

Accepting the theory that cholesterol is directly related to some coronary artery diseases, then an explanation should be made of the instances noted in the literature of coronary occlusion without an elevation of blood cholesterol having been reported. At present, no explanation is available. Yet the usual report, in recent date, is one of an increase in cholesterol following a coronary thrombosis. In view of this result serious consideration of all factors is necessary before definite information can be assured.

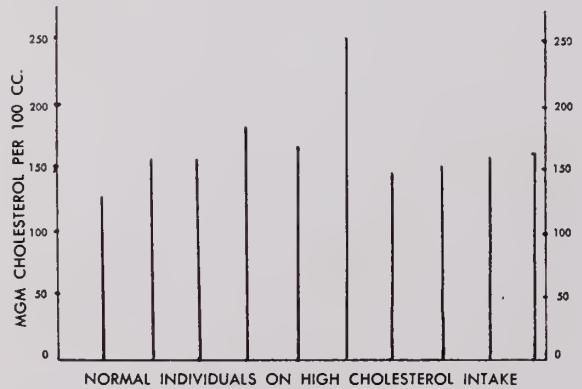


FIGURE II

Since elevated cholesterols can be lowered by diet, it seems feasible that the nine cases which did not show an elevation, while consuming much cholesterol daily, have demonstrated a tolerance towards it. This leads to the possibility that a condition, as yet undefined, may exist wherein the individual handles cholesterol poorly and this condition, in turn, causes atheromata to form. An analogy might be drawn with the diabetic, or the gouty individual, in whom the inability to handle sugars and purine-derivative-producing foods can be demonstrated by the test on their fasting blood. The effects of this intolerance is shown in the pathological findings both in diabetes and in gout. To me, it seems more than a coincidence that elevated blood cholesterol is found in the patients with atheromata which contain cholesterol in good quantity.

If the same proven principle and pattern successfully used in diabetes and gout is now applied to this particular problem, then it does not seem unreasonable to state that the intolerance itself is responsible for elevated blood cholesterol, which encourages atheromata formation. As yet, the findings do not warrant complete affirmation of such a view and one naturally proceeds cautiously. Certainly, a new avenue of investigation, one of determining intolerance, is evident and appears worthy of wide consideration.

Conclusion:

From the review of the literature and from extensive personal investigation, I believe two conclusions can be entertained in this early stage of inquiry.

(a) Since cholesterol appears more and more related to some vascular changes, it will be of real value to estimate the individual's cholesterol tolerance early in life. If this tolerance is lacking then the patient should be guided by a cholesterol poor diet in an attempt to maintain a normal blood level.

(b) The microscopic picture of the atheromata and the instances of the two deaths cited above, indicate the possibility that atheromata, once formed, can not be decreased by the lowering of the blood cholesterol level.

WILMS TUMOR*

Report of Two Cases in the Same Family

MIHRAN A. CHAPIAN, M.D.

The Author. *Mihran A. Chapian, M.D., Chief, Urological Service, The Memorial Hospital, Pawtucket, R. I.*

WILMS tumor is the most common malignant abdominal tumor found in children. It is rare in the adult. It has an extremely high mortality rate and effects the male and the female alike. It is found with equal frequency in the right and left kidney. Histologically, Wilms tumor is an embryonal mixed tumor, usually adeno-myosarcoma, but its pathogenesis is still unsettled. It is radiosensitive. There is no proof that trauma or infectious diseases have any bearing on its development. Metastasis to the lymph glands and distant metastases to the lungs and liver are late in the disease.

A painless swelling on one side of the abdomen is the first sign of Wilms tumor in the majority of the cases. Hematuria is relatively uncommon. Diagnosis is made by the presence of a tumor mass and urographic studies.

The following two cases in the same family are of interest and worthy of reporting. Case 1. C. F., male, age 3, normal delivery at full term, was admitted to the pediatric service on March 22, 1944, and seen in consultation by the urological service. The mother stated that the child had been perfectly well until three months ago when she noticed a hard lump on the right side of the abdomen. Shortly after the mass was noted, the child complained of general abdominal pain which lasted several hours. There was no vomiting nor elevation of temperature. One year ago he was knocked down by an automobile but no serious injury resulted. Family history was irrelevant except that the father's grandmother had seven children, 4 boys and 3 girls, and all 4 boys died at about the age of 2 years of unknown cause.

Physical examination revealed a well developed and fairly well nourished but rather pale, 3-year-old male child, not acutely ill. Temperature, pulse and respirations were within normal limits. There was a soft systolic murmur at the apex. There was a large, non tender, firm mass on the right side of the abdomen extending to the midline and below the crest of the ilium. Genitalia were normal. The urine was essentially negative. Red blood cells were 3,480,000. Hemoglobin 7.5 gms. White blood cells 9800. Blood urea nitrogen 14.5 mgs. Wassermann and Hinton tests were negative.

An intravenous urogram showed a normal left kidney. On the right side there was a large mass extending down to the pelvis. There was no evidence of contrast medium on this side. X-ray examination of the chest was negative.

A diagnosis of Wilms tumor was made and the child received 4 blood transfusions, a total amount of 1000 cc. In the meantime, deep x-ray therapy was started and a total dosage of 1568"r" was given in the course of 15 days. It caused noticeable shrinkage of the tumor but the treatment was discontinued due to severe toxic reactions.

Transperitoneal nephrectomy was carried out on April 26th. The renal pedicle was ligated first and the tumor mass removed. The wound was closed without drainage. The specimen was round and smooth in outline and measured 19x12x10 cm. Microscopic examination revealed scattered areas of muscle tissue with inclusion of glands and a large amount of connective tissue. Only a few distorted glomeruli could be recognized. Pathological diagnosis was Wilms tumor.

Convalescence was uneventful and the wound healed per primum. Immediate postoperative irradiation was thought inadvisable due to severe toxic reaction caused by preoperative treatment, and the patient was discharged on the 29th postoperative day.

The child was seen periodically by Dr. Thomas P. Sheridan of the pediatric service and showed progressive improvement. However, when he was brought for x-ray treatment on September 18th, there was evidence of metastasis to the supraclavicular region and a palpable mass was present at the site of the operation. These lesions almost completely disappeared following irradiation with a total dosage of 1222"r". When seen again 5 weeks later, there was a large gland on the left side of the neck and a large mass occupying the right side of the abdomen. The child rapidly went

continued on next page

* Presented at the John F. Kenney Annual Clinic, at The Memorial Hospital, Pawtucket, on October 29, 1947.

downhill and died on November 17th, six and a half months after the operation.

Case 2. J. F., brother of the previous patient, age 3, normal delivery at full term, was admitted to the pediatric service on June 18, 1945, and seen in consultation by the urological service. The mother stated that the child complained of abdominal pain during the past 24 hours and did not eat well and was constipated for three days. His previous admission was on January 4, 1945. A diagnosis of meningococcus meningitis was made and he was discharged 3 weeks later, fully recovered.

Physical examination revealed a well developed and well nourished but somewhat pale, 3-year-old male child, lying quietly in bed. Temperature was 102, pulse 100 and respirations 22. There was a blowing systolic murmur at the apex. Abdominal palpation revealed a fairly large, non tender, smooth mass in left upper quadrant extending just below the level of the umbilicus. Genitalia were normal. Urine was entirely negative. Red blood cells were 3,830,000, hemoglobin 9.5 grams and white blood cells 19,950. Blood urea nitrogen 8 mgs. A preliminary x-ray film showed a soft tissue mass on the left side of the abdomen. An intravenous urogram showed a normal right kidney. Left pyelogram was essentially negative except that the lower calyx was not well visualized and the upper portion of the left ureter was displaced mesially reaching the midline of the lumbar spine. Retrograde pyelography gave similar results. X-ray examination of the chest was negative. Likewise, barium studies of the gastro-intestinal tract gave negative results.

In view of the above findings, a diagnosis of Wilms tumor was made. Pre-operative x-ray treatment was not given in this case for fear of toxic reaction as experienced in the previous case, and, also, because this was not a very large tumor and no great difficulty was anticipated in its removal.

Transperitoneal nephrectomy was done on July 6th and again the wound was closed without drainage. The specimen measured 12x12x10 cm. On section there was a small area where normal parenchyma could be recognized. There were several cystic areas just beneath the cortex. The remainder of the specimen was made up of a spongy, yellow to grayish white mass. Microscopic examination showed contracted glomeruli, degenerated tubules and a reticulated structure. Pathological diagnosis was Wilms tumor.

Postoperative course was smooth and the incision healed per primum. X-ray treatment was started 14 days after the operation and a total dose of 4123"r" was given in a period of 20 days. At the time of his discharge on August 8th, he looked fairly well and was quite active.

This patient was followed up at the Tumor Clinic. When seen on September 20th, he looked well and no evidence of the disease was noticeable. However, ten days later, a small mass was palpable at the left lower quadrant and the child appeared listless. X-ray treatment was resumed and a total dose of 1504"r" was given in the course of 24 days. On the last day of treatment, no evidence of tumor could be detected. Three weeks later, abdominal examination revealed the presence of ascites indicating metastasis to the liver and the portal system and the child looked cachectic. He was readmitted on November 15th. Paracentesis was done on two occasions and each time about 2000cc of hemorrhagic fluid was obtained. The child lost ground rapidly and expired on December 25th, 5 months and 19 days after the operation. Autopsy was not done.

Seven months ago the parents had a third boy, delivered normally and at full term. This child was examined 12 days ago and found perfectly normal. Intravenous urography, done 3 days later, was entirely negative. It is our intention to examine this child at least every 3 months and carry out urographic studies every 6 to 9 months in order to detect early any evidence of this disease that may be present and try to save him from the fate of his brothers.

Discussion. 1. Familial tendency: In spite of vast amount of literature dealing with Wilms tumor, reports of authentic cases in the same family have been rare. Walker, Strumpell, Deuticke and Bobbio have reported cases occurring in the members of the same family but these were not all proved by operation and tissue examination. However, Maslow, in 1940, reported Wilms tumor occurring in one brother and two sisters, all three proven by operation, and another brother in whom a diagnosis of Wilms tumor was made but operation was deemed inadvisable and autopsy was not done. As far as the writer was able to ascertain, this communication is the second report of Wilms tumor in the same family proved by operation and pathological examination. This report and the previous ones by the above authors seem to indicate a familial tendency to this disease.

2. Treatment: It is generally accepted that nephrectomy and postoperative irradiation are necessary procedures in order to accomplish a cure, if at all possible. However, there is some controversy in regard to preoperative irradiation. Those in favor of it claim that by the shrinkage of the tumor, the operation is rendered easier and the operative mortality and postoperative morbidity are lessened. On the other hand, Ladd and his followers claim that Wilms tumor of any size can be removed by an anterior transperitoneal approach and that the longer the operation is postponed the

continued on page 109

THE PATTERN WAS ESTABLISHED*

GUY W. WELLS, M.D.

The Author. *Guy W. Wells, M.D., of Providence. President of the Providence Medical Association, 1947.*

THE Providence Medical Association will celebrate later in the month its One Hundredth Anniversary with fitting recognition. Plans for the occasion have been under consideration for the past year.

However, without encroaching on the speakers for that meeting, it seems appropriate, even essential, that we pause here tonight to reflect for a few minutes on the past one hundred years of medicine as this Association has experienced it.

The beginning of the nineteenth century is not arbitrarily called the beginning of modern medicine. There are definite reasons, without which medicine would have continued as it had in the past, with here and there the product of a brilliant mind pretty completely buried or limited to small areas near medical colleges. Harvey's DE MORTU CORDIS in 1628 is an example; Malpighi's description of the capillary system in 1661 is another. There were many other giants in the earth through the seventeenth and eighteenth centuries but they were isolated and apart from the average mind.

The American and French revolutions freed the minds of mankind in large areas of the world and opened the door to an unlimited horizon. Although the American Colonies had fewer physical resources and establishments at the time, the inhabitants of a young and virile nation do not appear to have been deterred from making their own opportunities and from prosecuting with vigor their own conceptions. Newspapers and early American books give plenty of proof that every citizen enjoyed his right to think. Many and varied were the societies formed for study and interchange of knowledge. These were emergency measures to take the place of physical equipment that already existed in long-settled countries. The inspiration and stimulation must have been great, for America grew in mental stature.

* Presidential Address Before the Providence Medical Association, at Providence, Monday, January 6, 1948.

Europe was naturally the center of learning, and many from the United States studied in European universities. The sciences were advancing rapidly the latter part of the eighteenth and early nineteenth centuries. Mathematics, physics, chemistry, and biology advanced rapidly. Helmholtz announced his theory of Conservation of Energy; Bernard describes the liver function for converting and storing glycogen and states that trauma to the floor of the 4th ventricle produces glycosuria. Darwin's ORGIN OF THE SPECIES did a great deal to clarify biological thinking and to start biology on a firm foundation for rapid progress, that has continued up to the present time.

Medicine, utilizing every branch of science, is dependent on the growth of science for its own development. The brilliant scientific period of the first half of the nineteenth century furnished the necessary foundation for medicine to reap the inevitable benefits, and so it was about the year 1847 and 1848 when the Providence Medical Association, one hundred years ago this month, was formed. At practically the same time were formed the Royal Academy of Sciences in Vienna; the American Association for the Advancement of Sciences: the Societe de Biologie in Paris; the American Medical Association; and the New York Academy of Medicine.

Problems existed in 1848 and were as acute as they are today. The constitution of the Providence Medical Association in 1848 mentions separation of the Regular from the Irregular practitioners, promotion of the character, interests, and honor by maintaining union and harmony in the profession, elevation of the standard of medical education, cultivation and advancement of science by united effort for mutual improvement. Are not these reasons exactly the same that we would give today, after one hundred years?

It is interesting that one of the first important matters discussed and settled was minimum fee tables, and the committee did it in a period of nine days. Do fee schedules sound familiar — all but the nine days? They wasted little time from there on, organization was about completed, delegates to the national convention were elected, one of the original members was summarily dropped

continued on next page

for using the Association's name in a public advertisement. It was regarded as derogatory to the dignity and honor of the Society. A committee was appointed to secure in advance performances of a scientific and practical nature for each monthly meeting. The Association was well on its way to secure for itself the objectives enumerated in the constitution. The programs were formal followed by discussions.

The first year the members gave case reports on diseases of the femur, papers on dysentery, "hooping" cough, and typhoid fever. Specimens of typhoid ulcerations of the large and small bowel were shown at the same time. Etherization in midwifery occupied two successive meetings, and the Association appointed a committee to find room for a medical library.

It is not the intention of this paper to recite the history of the Association, for others will do that later with better effect. This much is necessary for the sake of comparison.

It is interesting to note the purposes of the Association in our recently revised constitution. Again are mentioned the advancement of sound medical science and the promotion of character, interests and honor of the medical fraternity, and harmonious unity of purpose. We have specifically stated other objectives, such as stimulation in activity in civic health and general welfare, and interest in enactment and enforcement of just medical and public health laws. Also we affirm our support of the State Society and of the American Medical Association. The year after the founding of this Association, 1848, three delegates were elected to attend the national convention in Boston. In a short time committees were elected to advise the Mayor on matters of public health and general welfare.

The history of early medical societies reveals that a large number of them sank into oblivion within a short time of their founding. A glance at the constitutions of a few might explain their failure. Most of them had little reference to improvement of medical science or education. Some did not offer a scientific program. There were infrequent references to the honor and integrity of the profession. Some were reorganized, often under a different name. The continuous, progressive growth of the Providence Medical Association is not surprising, when we consider the principles set forth in the constitution by the Founders are more vital to progressive medicine today than in the year of 1848. That is probably the chief reason for its vigorous growth. Men who could think for at least the next one hundred years certainly had a deep bond of interest and could hardly have failed to attract other men of like caliber. They established a pattern for monthly meetings, that has scarcely changed from that first year. Minutes of the previous meetings were read. Committees assembled facts and made recommendations. The issues were settled by vote, and the scientific part of the program, announced at least one month in advance, got under way. At the annual meeting, officers gave their reports, and all officers were elected for the coming year.

Today the Association has expanded greatly, in numbers and in other fields of interest both to the public and to the medical profession. We now meet in, and have the privileges of the Rhode Island Medical Building and its splendid library. That surely would have pleased Dr. C. W. Parsons. In place of one standing committee there are now twelve, embracing such subjects as air pollution, curative workshops Inc., ethics and deportment, legislation, milk, tuberculosis, and water pollution. An executive committee carries on the routine business and organization work. Other special committees are appointed for special work as needed. The scientific program has always been stressed, from the beginning of the Association to the present time, and probably accounts for the regularly large attendance.

A little before the beginning of this century a new feature was added that might be considered by this body. Committees were appointed and assigned months to report the year's progress in such subjects as anatomy, histology, pathology, and bacteriology—Doctors Chapin and Swarts were on that committee. Other subjects were physiology, chemistry, surgery, diseases of children, Materia Medica, and therapeutics, hygiene, obstetrics, and gynecology. Surely that was an ambitious program and designed to elevate the standard of medical education and quality of medical service in a vigorous manner.

It was early 1887 that Dr. Gadding reported an interesting history and autopsy report of one of his patients. After a slight muscular strain she was seized with a severe epigastric pain radiating to the arms, particularly the elbows and finger tips. Within a short time she died. Post-mortem examination revealed a ruptured left ventricle and two ulcers of the aorta, between which the lining membrane had separated. It is too bad that we do not have his actual words instead of a resume by the secretary, for this case antedates Dr. James Herrick's famous paper by twenty-five years.

Without attempting to estimate the value of our recent activities, that would be most presumptious, the Providence Medical Association seems to be carrying on, about as the Founders hoped and planned. Interest in the programs is evident by the attendance, which appears to be fully as large as those of similar societies in comparable communities. Improvement in medical education and sci-

ence seems to have been one of the Association's major purposes.

Public welfare and service is the other major objective. In recent months this body aroused the public to the effect of air and water pollution. It is interesting to note the public's quick response and their cooperation with the formation of committees to work for enactment of legislation to control such pollution. Other committees, such as the one on Sanitation in Eating Establishments, have rendered a great service to a most grateful public and the response has been stimulating.

We have taken an active interest in economic questions, so far as they concern the patients' ability to secure medical attention. Like the first meetings of this organization and nearly all other similar groups of the time, we have been engaged in minimum fee schedules for the low-income group and are even now about to launch an insurance plan for their protection. Without doubt this plan will be extended in the near future. Cash Sickness Benefits and the Workman's Compensation Act have both received a good deal of attention and study from us.

One wonders what subjects will occupy this Association in 2048. It would be impossible to predict. May we humbly hope and strive to make our efforts sufficiently valuable to excite their admiration as have the Founders of the Providence Medical Association won our admiration.

And now, if these records still exist one hundred years from now, let us extend to the readers of them our sincerest good wishes for their success.

WILMS TUMOR

concluded from page 106

greater the possibility of metastasis. Our own experience in dealing with Wilms tumor has led us to resort to immediate nephrectomy when confronted with relatively small and medium-sized tumors and employ preoperative irradiation with large tumors when technical difficulties in their removal outweigh the possibility of metastasis during the intervening period of a few weeks.

The advantage of transperitoneal approach when operating for Wilms tumor lies in the fact that the renal pedicle can be ligated first, before attempting to mobilize the tumor mass and thus avoid escape of tumor cells into the blood stream. Aside from this consideration, transperitoneal route is preferable when dealing with large tumors difficult to be removed through an extraperitoneal lumbar incision.

Drainage through a stab wound in the flank was not done, contrary to the practice of many urologists. As stated above, both of these cases healed per primum. If one is careful to obtain complete hemostasis, I believe drains will not be necessary.

Summary: Two cases of Wilms tumor in the same family are reported. Both of these children were male. In one case the right kidney and in the other the left kidney were involved. Both ended fatally. The familial tendency and mode of therapy discussed.

I wish to thank Drs. Earl F. Kelly and Thomas P. Sheridan and other members of the pediatric service for their wholehearted cooperation in the management of these two cases.

PNEUMOCOCCIC LOBAR PNEUMONIA

continued from page 102

monia by two to three days, in addition to markedly reducing the mortality.

4. Sulfonamides are as effective as penicillin in reducing the length of the natural history of the disease, but cause some complications. Treatment of pneumococcic Lobar Pneumonia with daily penicillin dosages in excess of 300,000 units appears to be the ideal treatment in that the duration of the disease is shortest and complications of the disease and treatment are minimal.

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THE PMA CENTENARY

One hundred years is a dignified age, even in Providence. The Providence Medical Association, which celebrates its centenary this week, was founded during the Mexican War when our city had about 40,000 inhabitants and hospital facilities consisted of Butler Hospital, Dexter Asylum and a pest house for cholera and smallpox, which were serious problems in those days.

Mutual support in economic matters was a strong factor in bringing these physicians together, but the records show that, having once become properly organized, they devoted their meetings to the art of medicine and to its science as it slowly developed.

The small size and compactness of Rhode Island had rather naturally resulted in the formation of the state society first. As population concentrated, however, the local physicians found it convenient to work together without the difficulty of association with their outside friends, kept away by awkward traveling conditions.

Hence the Providence Medical Association grew larger than the Rhode Island Medical Society, for many physicians saw no need of joining both. Although this has been changed now and the state society is larger and dominant, the volume of scientific and educational work remains greater in the association's eight meetings yearly.

Some of the former members' names are still familiar despite the lapse of time. At the beginning was Usher Parsons, surgeon to Perry at the Battle of Lake Erie and brother-in-law of Oliver Wendell Holmes. Most famous was Charles V. Chapin, who revolutionized public health work and conceived the Providence City Hospital. His ideas about the care of infectious diseases, executed by Dennett L. Richardson, brought visitors there from all parts of the world.

The standards of the association are still high. Many of the younger and middle-aged men are doing the finest of work. So are those with a few more years to their credit. Dr. Halsey De Wolf performed an arduous duty with great judgment when he took charge of the procurement and assignment for doctors in the recent war. Dr. Frank T. Fulton has been one of the leaders in the development of cardiac studies for a good part of this century.

A week of displays and publicity featuring the history of this revered institution will be climaxed on Jan. 31 by an historical address at the Medical Library in the afternoon and a dinner with appropriate exercises in the evening.

May the second hundred years of the Providence Medical Association be as successful as its first.

Reprinted from THE PROVIDENCE JOURNAL—January 26, 1948

QUANTITY VERSUS QUALITY*

Recently the editor spoke to one of the most scientific members of our local profession and remarked that we liked to produce, ourselves, the matter that filled our columns. We preferred not to copy but we nevertheless expressed such appreciation of a recent editorial in the New England Journal of Medicine that we thought of reprinting it. Our friend replied "I think it ought to be reprinted once a week".

There has been a lot of spacious talk regarding the extension of medical care. Statistics are quoted to show the crying injustice of having many counties in the United States without a hospital. Bristol County, Rhode Island, is one of them. Yet its residents can reach the hospitals of Providence easier than some of the residents of Providence County. Much is said of the dearth of general practitioners. Yet it would be futile to increase the number of poorly trained ones. See paragraph four in the following editorial. It is refreshing to read this discussion of Quantity versus Quality from the New England Journal of Medicine, October 16, 1947.

—The Editor

Much of the thought concerning the distribution of medical care is based on the assumption that there is a store of unused potential medical care that should be properly distributed. We have sowed, harvested and gleaned our learning over the years. Now we are garnering it; let us open up the bins and release it to a long-starved public!

This idea suffers on closer inspection. Medical care consists of knowledge, applied by men to patients. This knowledge is the working capital of medicine, built up through centuries of experience and decades of research. We often proudly refer to modern medical knowledge as of "huge extent" or "staggering proportions," and relative to the accumulated facts of a century ago, this is true. Yet in any given area, knowledge is not so massive that it cannot be encompassed by the human intellect. Knowledge simplifies as it progresses, and multiple ill understood theories are swept away by the strong currents of new basic facts. Each significant advance in medicine renders obsolete a multitude of former writings or practices. There is nothing overpowering in the amount of our present knowledge, but the application of this knowledge to sick human beings is a complex and difficult affair that requires the use of the second medical resource, men. Without men who can apply it properly, medical knowledge is sterile. Unfortunately, an M.D. degree confers neither wisdom nor honesty on the recipient; wisdom in its broader sense includes not only factual knowledge but also the ability to apply knowledge with judgment and mercy. Honesty is the *sine qua non* of medicine, without which medical practice degenerates into the collection of the fee without the contribution of commensurate benefit.

The question at hand is, Do we have any reservoir of men to apply our knowledge, any reservoir that is not drained, any potential that is not kinetic? Do we have any group of competent men whose present time-budget is ready for the expanded services of a legislative medical plan? A moment's consideration will reveal that we do not have such an unexpended surplus; indeed, we are operating with a deficit.

For all their effectiveness, modern medical technics are dangerous and medical knowledge is of little avail unless applied by men of wisdom and integrity. Modern tools enforce on us the necessity of becoming better craftsmen. When medical care was simple and ineffective it was also harmless, and the fine exercise of judgment required of the present-day physician, working with his sharp and penetrating weapons, was less frequently required. Yet the raw material from which physicians are fashioned has not changed since the day of Currier and Ives.

Recognition of the fact that the American medical profession is not perfect constitutes an unpopular viewpoint in this day of propaganda and institutional advertising; even the pharmaceutical industry seems to be in league to inflate our ego and whitewash our shortcomings. The precient, sentient and omniscient doctor-scientist of the motion pictures and advertisements has become a fixture in the public mind and therefore in ours. Unfortunately, however, the profession does leave much to be desired; this is no disgrace, for any group of 160,000 men is too large to be called "select." The members of the medical profession possess all the virtues and all the faults of any large cross section of population. In addition to the wise and honest doctor-scientists, we have our full share of loud-mouthed snap diagnosticians; and researchers who are long on theory but short on judgment are as numerous as surgeons whose concern for the patient fades if convalescence is stormy.

These facts and this deficit of quality are disturbing only if we set out to distribute our allegedly undistributed medical care by legislative extension of medical services. In creating a broad national medical-care plan it should be recalled that the harm done by poorly qualified men becomes multiplied as the square of the number of patients they treat. There are all two few physicians who exemplify the best in the profession, and they are already overburdened.

continued on page 113

GUEST EDITORIAL

AN EXCURSION AMONG THE EPONYMS

"But these are deeds that should not pass away, and names that must not wither."
Byron, quoted by Jessie Dobson.

In the past, and that not so far distant, we have enjoyed the scholarly yet picturesque talks of Dr. George Blumer of Yale. Dr. Blumer is now retired and is enjoying in California what he would probably call, were the expressions not so trite, his dolce far niente or his otium cum dignitate.

But it is not in Dr. Blumer's nature to do nothing, and he has recently written some delightful editorials for the Connecticut Medical Journal. Dr. Elihu Wing is a friend of long standing of Dr. Blumer, and it is thanks to that that we are privileged to print the following editorial by Dr. Blumer.
—The Editor

Almost fifty years ago, "in my salad days when I was green in judgment", I wrote an editorial entitled "The Use of Proper Names in Medicine".* In it I decried the habit of labelling new diseases and new symptoms with the names of their discoverers, mainly on the ground that "the unfortunate medical student, who is already overburdened with work, is compelled to memorize a series of names, some of which are doubtless those of eminent men, but others those of individuals whose only claim to posterity is their association with some minor symptom or ailment." It is possible that this attitude was at least partly due to the fact that I was then only a decade from my early student days and had not entirely sloughed off the memory of the then prevailing lecture system with its hours of note-taking on hard benches. But, be that as it may, I no longer look on Eponyms with a jaundiced eye and, agreeing with Emerson's dictum that "a foolish consistency is the hobgoblin of little minds," I have changed my views regarding them.

The custom of associating the names of discoverers with the observation and description of new phenomena and new objects permeates all the Sciences and is by no means confined to Medicine. As I look out of the window I see a bougainvillea, and the names of Wistar, Forsyth, and even popular heroes like Fremont, are associated with well-known plants. As Jessie Dobson says in her book, Anatomical Eponyms, "botanical nomenclature serves as a directory of the great pioneers in the study of that subject." The zoologists, the physicists, the chemists, the geologists, and in Medicine the bacteriologists, the pathologists, the physiologists, the chemists and the clinicians all use personal names at times. Even our newspapers are invaded by such terms as Kilowatt, degaussing, and many other eponymic words, not to mention every day adjectives such as herculean, rabelaisian, venereal.

Theoretically, at least, a medical term should be descriptive, and in the case of a disease, should give clues as to the etiology and pathology of the condition. The fact that the names of some diseases meet these requirements and that others entirely fail to do so is evidence of the lack of a generally accepted plan governing nomenclature. The anatomists with their B.N.A. have tried to tackle the problem scientifically with the result that they have demonstrated pretty conclusively that a given group of men in any science would almost surely fail to reach a unanimous agreement to eliminate eponyms. There was a period in the Eighteenth Century when the French botanist and physician De Sauvages tried to introduce a sort of Linnean classification of diseases on which the English clinician John Mason Good tried to improve. The result was an appaling and cumbersome mess of verbiage which was never widely adopted and soon sank into inocuous desuetude. In clinical medicine new diseases arise from time to time or opinions regarding old maladies have to be revised in the light of new discoveries. It is only occasionally that all the facts as to the etiology and pathology of a disease are known when it is first described, indeed there are even now old diseases, some of which have been known and recognized clinically for generations, whose etiology is still a mystery; one need only instance one of the commonest of all affections, arteriosclerosis, as an example.

In addition to burdening the memory of the physician and the medical student the use of eponymic names for diseases or syndromes has other disadvantages. Very often the individual who first described the disease does not get the credit, though since the publication of the Index-Catalogue of the Surgeon General's library, the Index Medicus, and the Quarterly Cumulative Index this

* Albany Medical Annals 1899, *20*, 613.

is less likely to happen than in former days when an interminable search through available literature was necessary to try and ferret out the question of priority. Combe gave a pretty good account of pernicious anemia years before Addison did; Vieussens described Corrigan's pulse before Corrigan was born, and many other similar incidents could be cited. The question that such occurrences always raises is this: who should get the credit the man who originally describes a disease, perhaps reporting a single case only, or the man who really "puts it on the map", usually by studying and analyzing a series of cases and presenting a detailed and systematic picture? Then, too, several men may discover the same disease independently, so, for example, the names of Graves, an Irishman, Parry, an Englishman, and Basedow, a German, are all attached to Exophthalmic Goiter, and Polycythemia Vera is often named the Osler-Vaquez disease. The fact that the name of a disease may give no clue to its nature is a valid criticism of the use of eponyms, but one on which too much stress should not be laid. Many eponymic diseases also have scientific names and, as a matter of fact, if their nature is obscure, they may have many such. One has only to read the history of Hodgkin's disease with its multiplicity of synonyms to realize this. Furthermore it does not take students or practitioners long, if they are really interested, to learn the various names of eponymic diseases and to associate them with the etiology, the pathology and the clinical picture.

What are the advantages of an eponymic nomenclature? Brevity is sometimes one of them. It is easier to say Bamberger-Marie's disease than hypertrophic pulmonary osteo-arthropathy. Another advantage is that, for the most part, it gives credit where credit is due and, most important of all, it encourages the study of medical history, which, like other history, is mostly biography. It was always dangerous for a house officer or student of William Osler to use an eponym. He would almost certainly be asked who the man was whose name he had used, and if he didn't know he would be told to look it up and report to the group at a later date. William Allen Pusey, the well-known dermatologist, once wrote an article entitled "The Importance of Being Historically-minded", and there is no question that knowledge of the past is essential to the formation of a well-balanced judgment of the present. Studying history through biography is one of the most attractive ways of acquiring knowledge of the past, and this aspect of the eponymic diseases outweighs, I think, all the objections to this type of nomenclature.

QUANTITY VS. QUALITY

concluded from page 111

How can this deficit be met? Is there any way of multiplying the good medical care dispensed by one person? In a limited sense, yes. One occasionally encounters that happy circumstance in which an older man surrounds himself with a group of devoted and effective residents or associates in a hospital or clinic and thus extends his reactive interface with the public. But this is a rare phenomenon. More frequently the able, older man becomes increasingly absorbed in administrative or other noneffective duties that enhance his national reputation but limit rather than extend his contact with the public. This type of work should be delegated to personnel trained for that purpose, not to the best clinicians and investigators.

Is there any way of increasing the total number of effectives? Better recruiting should be the answer. The admission committees of medical schools must raise their standards by every honest means. The interest and enthusiasm of the most capable undergraduates in the colleges must be aroused. The breed must be improved, even if it requires artificial insemination!

Until we have succeeded, let us not try to dispense to the public more medical care than we possess. We must meet our present deficit of quality before incurring any more obligations for quantity. One may raise the objection that the public will not wait — that labor unions or insurance groups will insist on the extension of medical care. Let them light the fire; they will be badly burned and learn their lesson. Some well intentioned and well financed group will establish a medical-care plan and, by chance or ignorance, will place it under the direction of poorly qualified physicians. The patients will be cared for by men with "pet theories," which were formerly inflicted on relatively small groups of private patients, or by surgeons long on speed and short on incisions. But these patients will not drift off into the happy limbo of another man's practice. They have made their prepayments over the years and they will return for amends; the bad news will gather like flies around offal on a hot summer day. The backers of this scheme will come to realize that, although their expenses have been met, they are operating under a deficit — a type of deficit peculiar to medical undertakings.

The definition and control of competence is the central problem of medicine today. It seems wiser to move toward the solution of this problem than to multiply the total number of doctor-patient contacts by legislation.

*Reprinted from *The New England Journal of Medicine*, October 16, 1947.

GROUP MEDICAL PRACTICE*

FREDERICK T. HILL, M.D.

The Author. *Frederick T. Hill, M.D., of Waterville, Maine. Director, Thayer Hospital, Waterville; Trustee, Colby College.*

GROUP PRACTICE may be defined as the pooling of professional and material resources with the objective of more efficient medical service, economically advantageous both to patient and physician. It should represent the practice of diagnostic, therapeutic and preventive medicine by an integrated group of physicians, including general practitioners and qualified specialists in as many different fields as possible.

The greatest criticism of American Medicine, and about the only one freely admitted by everyone, is that the prevailing system for distributing medical care is decidedly inefficient. There is no doubt that this phase of medicine has not kept pace with its technological advances, so that the best service is not always available to those needing it. The main problem of medical care today is that of distribution.

The realization of this has influenced the consideration and development of group practice as one means of providing better distribution. Experience has shown that a rather high percentage of cases require the attention of specialists in various fields, if the best of medical care is to be provided. This can be met most effectively in most cases by group practice, where by centralization of resources specialist skill can be effectively utilized and compensated for. It has been estimated that group practice can increase the efficiency of delivering medical service by 50%.

Unfortunately too much emphasis has been placed upon the economic phase, rather than upon the more important objectives of better medical service. And, unfortunately, too many groups have been formed, or entered into, with the main idea of financial gain, or at least making money with less effort.

While there are, of course, definite economic advantages through the pooling of material resources, the greatest reason for group practice is in the improved quality of medical service that is made possible through the facilitating of consultations and of group study. The greatest value would seem to be in the increased emphasis upon cooperative professional effort, with better diagnoses and less delay in effecting proper treatment. How often do we see a patient with some obscure condition making the rounds of physicians until finally a diagnosis of carcinoma is made by the specialist in some particular field? Group study at the onset might have indicated the diagnosis and allowed for effective treatment before the condition became too advanced.

The real argument for group practice should be that by pooling professional resources better and more scientific medical care is made available for more people.

Group practice means something more than several physicians with adjoining offices, sharing in certain items of overhead and exchanging consultations among themselves. It means actively and conscientiously using their combined professional skills, and mutually accepting the responsibility for the care of the patient.

In general there are three types of Group Practice prevalent in this Country. The best and most efficient type is that with University or teaching hospital affiliation. While the degree of affiliation may vary, there is an inevitable tendency to maintain high standards and they are the least affected with the taint of commercialism.

Another type, usually designated as a Clinic, may be quite independent of academic affiliation, or this may develop later as a result of successful operation along scientific lines so as to make its resources appealing to a medical school or teaching hospital. Most of these are either privately owned or may be in the nature of a partnership or a corporation with the physicians as share holders.

A third and more recent type is that organized around some sort of pre-payment plan, on insurance principles. In some cases this type of group may base its activities in some hospital; in others, it may use independent hospitals.

Good Medicine, whether individual or group, should aim to provide the best possible diagnostic and curative service at a cost consistent with the patient's financial status. Illness should not entail economic catastrophe. Loss of earning power

continued on page 116

* Presented at the Third New England Institute for Hospital Administrators, at Providence, June 26, 1947.



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When dysmenorrhea is due to myometrial hypertonicity or excessive uterine contractions, prompt symptomatic relief may be obtained by the administration of—

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GROUP MEDICAL PRACTICE

continued from page 114

alone is enough of a burden to bear. Hospital insurance should be easily available to all employed persons through the Blue Cross or similar plans, and the hospitalization of the indigent properly should be met from general tax sources. The development of prepayment medical care insurance should lessen the burden of professional fees; but, whether or not, if Medicine is to retain its Time-hallowed reputation as the most humane of professions, it must not carry a price-tag. Fees, in all cases, should always be consistent with the patient's means.

Group practice has been criticized as being too elaborate for the ordinary type of illness, as tending to create cliques, as limiting the choice of consultants and of sometime providing substandard service from unqualified self-labelled specialists. The validity of these criticisms depends, to a great extent, upon the type of group and the individuals composing it. Like the hospital, any group will be only as good, or as competent, as its physicians. Any such plan undertaken primarily for commercial reasons, either to increase the physicians' income or even to reduce expenses, would hardly merit approval. Similarly any plan which limited the choice of consultants, or tended towards cliques based upon mutual self-interest could only meet with disapproval. The welfare of the patient always must be our first consideration.

For years the larger teaching hospitals have embodied the principles of group practice in the care of their service cases. Perhaps the outstanding feature in our changing professional relations in hospitals has been the gradual, often unconscious, extension of these principles to all patients. It has been the logical thing to pool professional resources in the hospital. This implies group study of cases whenever indicated, the liberal use of consultations and transferals to other services, or physicians, if the patient would benefit thereby.

Because of this tradition it is easy to understand why the type of Group Practice, affiliated with University or teaching hospital, usually has the highest standards, the most scientific methods and the least taint of commercialism.

If there be merit in this idea of group practice, if it will at least help solve the problem of more efficient distribution of medical care, could it not be applied in varying degree, at least, to the average community hospital? The voluntary hospital would not consider the privately, or corporation owned type but an adaptation of the first type, that with academic or teaching hospital affiliation would seem possible and desirable.

The principle that the hospital should assume the responsibility for the safety and the medical care of its patients, both service and private, is now rather generally recognized. The private patient is no longer to be considered the personal medical property of his physician. Rather he is the hospital's patient, under the care of the physician; but with the hospital through its staff, responsible for diagnosis and treatment. The consensus of medical minds of the staff should be available to determine whether or not proper treatment is being carried out. This may indicate the need of consultations, of additional diagnostic procedures, or a complete change of therapy, or even of physicians. At first hand this may seem revolutionary to some but if the patient is to be assured of the best care and the hospital is to live up to its responsibilities, this must be accepted.

And this, of course, is group practice in the hospital. And it's not new, or revolutionary. It's simply the adaptation to all patients in all hospitals of the accepted principles of what we have termed the teaching hospital, which has produced the best type of Medicine the World has ever seen.

In this connection I dislike the designation "teaching hospital". All hospitals, regardless of size or location, should be teaching hospitals. I say "should be" advisedly for I realize that many hospitals fail in this respect today. But each hospital should strive to develop the "teaching idea" in its daily routine. In no other profession is a program of Continuation Education so necessary as in medicine. So often the recovery, the health or even the life of the patient depends upon the skill and knowledge of the physician. And medical science is not static. What better place to carry on a program of Continuation Education than the hospital, every day and every week? Any good hospital will have teaching material if only it is made use of. This should include private as well as service cases. Often they provide the best material, that needed for teaching purposes. Patients, as well as physicians, benefit from case study. Self-education, after all, is the most valuable form of education. To neglect this, substituting an occasional short course in some teaching center, is both lazy and wasteful. It is time we were weaned from an exclusive regime of spoon-feeding. The weekly staff meeting, if properly planned and conducted, is one of the best forms of education. It can and should make all hospitals teaching hospitals. Hospitals will vary in size and in scope but all should strive for the same high ideals and have the same standards of service.

With this idea of group or cooperative practice it is easy to arrange for attendance at National and Sectional Scientific meetings, so necessary to enable men to keep abreast of medical progress. By dividing the assignments the staff may be represented at all the important meetings and the

continued on page 118

In behalf of the medical profession

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Some things you should know about the common cold

No. 209 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



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The danger of the common cold lies mainly in the other infections that may follow after it. For a cold lessens your resistance, and is likely to pave the way for other, more serious, respiratory ailments.

Sinusitus, ear infections, bronchitis, and the various forms of pneumonia are frequently ushered in by a cold. Pneumonia, particularly, is likely to attack a person who is overtired, or run-down because of a severe cold.

True, many of these respiratory diseases are not as dangerous as they used to be. (Modern infection-fighting drugs—such as penicillin and the sulpha drugs—offer highly effective treatment for many cases.)

But, of course, it is always better to *prevent* a serious illness whenever possible.

If you have a cold, it's just good sense to stay away from people, to avoid spreading the infection; and to get plenty of rest—in bed if possible.

If your cold is accompanied by fever, a persistent cough, or a pain in the chest, face, or ear, call your doctor at once.

The sooner you seek his help, the more he can do to help you avoid a long and serious illness.

And, in the case of children, an early examination may disclose that what appears to be only a cold may instead be a starting symptom of an entirely different disease, such as measles or scarlet fever.

SEE YOUR DOCTOR. Never try the foolhardy experiment of dosing yourself. Your doctor's treatment of one illness may be quite different from his treatment of another illness which appears the same to you.

Let your doctor diagnose your ailments. Let him decide what treatment is best for your particular case. Then follow his instructions to the letter. His advice is the only advice you should take on any question that concerns your health.

Makers of medicines prescribed by physicians

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proceedings reported back, while at the same time the patients are adequately covered.

In our own hospital we have gradually developed a system of cooperative effort in the care of the patient, which, while not strictly group practice, has resulted in such a pooling of professional resources. This has promoted better standards of medical service, provided better care of the patient and increased the scientific attitude of the staff. And the physicians like it and find it worthwhile.

This idea of cooperative practice works so well both for the patient and the physician, and is so logical and so productive of improved service, that it is bound to grow. There is great satisfaction for any physician in doing better, more efficient, more scientific work, such as is made possible by this pooling of minds and skills. It is one of the best means of attracting the desirable type of physician to the hospital. And those who will not subscribe to cooperation are not especially desirable and had best be eliminated. They will be far happier in other surroundings and the hospital will be better off without them.

Group or cooperative practice in the hospital is not difficult of application provided there be at least a semblance of departmentalization and a limiting of professional privileges according to the qualifications and competence of the staff physicians. Patients can be routed to the proper service and often to the best qualified man, or suggestions made for his coming into the case. Consultations can be encouraged and insisted upon, with a small ceiling fee for patients able to pay and freely given for those in poorer circumstances. Staff or departmental consultations on all serious or problem cases make for group practice. And this seems to work quite as well in the out-patient as with the house cases.

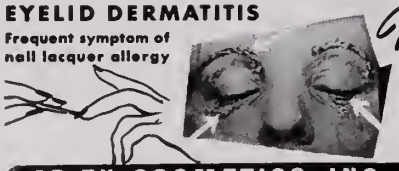
A logical step would seem to be the greater development of group facilities for diagnosis prior to hospital admission, and the utilization of these facilities for the treatment of ambulatory patients, not requiring hospitalization. If developed under the aegis of the hospital, this should be free of any taint of commercialism. There are sound professional and economic arguments for such a plan, such as readily available consultations, specialists services, X-ray and laboratory facilities anl the saving of the physicians time, a large portion of which is spent daily in the hospital.

I am not particularly concerned with just how this is done, provided the main objective of better diagnoses be achieved. Local conditions must be the determining factors, and cooperation, congeniality and mutual respect are essential. The full-time salary plan has certain advantages and also is open to certain criticisms. Many physicians are, by nature, rugged individualists and object to anything smacking of regimentation. And this plan calls for expert administration to succeed. In some circumstances the use of group offices in the hospital on a rental basis, with the unit system of fees for cases seen by the group, might be desirable. The fee should be based upon; first, the value of the service to the patient, considering his financial status, and second, the relative value of the services of the several physicians concerned. This type might be more adaptable to a group which was to include a number of older, well-established physicians. And as patients could come first to the physician of their choice, the personal relationship would be preserved. It is just a more efficient method of getting consultations, eliminating the psychological and economic barriers that often prevail.

The scope of such a group will, of course, vary according to the size of the staff and the various specialties represented. The small community hospital staff may consist entirely of general practitioners, with perhaps one man doing part-time X-ray work. Despite these limitations such a group could practice more efficient medicine than by working individually. Consultants from larger centers could be utilized when necessary. And as the need developed it would not be so difficult to attract specialists in different fields.

At the same time it is not necessary, and indeed may not be desirable, to include the entire staff membership in such a plan. There may be physicians serving the hospital most satisfactorily who might not be especially useful for the purpose of the group, or who would not care to become affiliated with it. A good working unit, including as many specialists as is possible, should be the objective, and members should be selected for their particular ability. With larger staffs the senior men ordinarily would be the natural selections, with the younger men serving in junior capacities. Services might be rotated, just as in the hospital. But these are details to be solved on the local level.

The main thing is to provide better professional service, both in the hospital and for the ambulatory patient, to substitute cooperation for competition, and to do this without imposing undue financial burden on the patient. And, above all, to accomplish this by a method devoid of political or bureaucratic control. It would seem a natural and logical development for the voluntary hospital.

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1. Gusberg, S. B., Am. Jl. Obst. & Gyn. 50:502, 1945

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HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY

Report of Meeting Held on January 21, 1948

A REGULAR MEETING of the House of Delegates of the Rhode Island Medical Society was held at the medical library on Wednesday, January 21, 1948. The meeting was called to order by President Arthur H. Ruggles at 8:40 p.m.

The following delegates were in attendance:

Rocco Abbate, M.D.
Charles J. Ashworth, M.D.
Philip Batchelder, M.D.
J. Murray Beardsley, M.D.
B. Earl Clarke, M.D.
Frank B. Cutts, M.D.
Morgan Cutts, M.D.
William P. Davis, M.D.
Donald DeNyse, M.D.
David Freedman, M.D.
Russell R. Hunt, M.D.
Albert H. Jackvony, M.D.
Earl J. Mara, M.D.
Edward A. McLaughlin, M.D.
John C. Myrick, M.D.
Joseph C. O'Connell, M.D.
Edwin B. O'Reilly, M.D.
Arthur H. Ruggles, M.D.
Daniel V. Troppoli, M.D.
George W. Waterman, M.D.
Frederick A. Webster, M.D.

Also in attendance were Dr. Stanley Sprague, Chairman of the Committee on Industrial Health, Dr. Clifton B. Leech, Chairman of the Providence Medical Association Advisory Committee to the Community Workshops, Inc., and Mr. John E. Farrell.

The secretary presented a brief report, a copy of which had previously been mailed to each member of the House. This report required no action by the House.

Industrial Health Report:

Dr. Stanley Sprague, chairman of the Committee on Industrial Health, reported as follows:

"At the November 24, 1947, meeting of the House of Delegates two recommendations were made after the report of the committee on Industrial Health relative to changes in the Workmen's Compensation Program had been adopted.

"These recommendations, referred to the Committee on Industrial Health were:

1) That in regard to the signs relative to the free choice of physician under the Workmen's Compensation Program larger type be used, and every effort be made by the Workmen's Compensation Agency to guarantee that the notice is posted prominently where it can be read by workers.
2) That the panel of physicians proposed should be available to private physicians who want their opinion substantiated that the patient can return to work.

"In relation to the first recommendation the members of the committee feel that this is outside their province in the first place, but that they do recommend that all copies of Workmen's Compensation Laws required to be posted in various factories, etc., not only be checked as to the fact of their posting but also be in larger type so that they may be more readily seen and read by workmen who are injured.

"Secondly, that if a medical advisory board is established by the Workmen's Compensation Commission, that this advisory board be available to individual physicians treating compensation cases to assist them in determining the ability of workers to return to their work. (It is often felt by the individual physician that his patient is ready but this patient cannot be persuaded to return and insists on further treatment. It is at this point that the committee feels that the physician should have power to request the review by this medical advisory board.)

"The committee, therefore, recommends that if the House adopts these suggestions the action of the House be transmitted to the State Workmen's Compensation Law Commission."

After brief discussion of the report of the committee it was moved that it be the expressed opinion of the House of Delegates that such industrial plants in Rhode Island as have a list of physicians on call in case of accidents occurring during working hours shall prominently display such list with a heading at the top stating clearly that the injured worker has free choice of physician at all times,

continued on page 122

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HOUSE OF DELEGATES MEETING

continued from page 120

and stating further that if the injured worker does not have a physician of his own choice, then the employer may call one of the physicians on the stated list.

The motion was seconded and adopted.

Communication from the Providence Medical Association:

A communication directed to the Executive Committee of the Providence Medical Association by the Association's Advisory Committee to the Community Workshops, Inc., was considered by the House of Delegates. This communication was referred to the House by the Association's Executive Committee because the matter involved an action taken by the House of Delegates at its meeting in November, 1947.

Dr. Clifton B. Leech, chairman of the Association's Advisory Committee to the Community Workshops, Inc., discussed the problem as presented in the communication. He stated his committee took exception to recommendation 5 in the report of the Industrial Health Committee as adopted by the House in November, which pertained to the use of the state curative center by private physicians, and he stated the committee expressed the hope that the House would withdraw its approval of that portion of the recommendation.

The matter was discussed at length by several members of the House, after which it was moved that the House of Delegates, having received and discussed at length the communication from the Providence Medical Association's Advisory Committee to the Community Workshops, Inc., place it on file.

The motion was seconded and passed.

Committee on Health Insurance:

Dr. Rocco Abbate, chairman of the Committee on Health Insurance, presented a brief summary of the present status of the surgical insurance program, citing that the policies of five major insurance companies have been approved and those of two other companies had been received that day for viewing by the committee. He also reported that a conference had been held with the Blue Cross and that organization had been urged to explore every possibility whereby it might participate and then present its proposal for participation to the committee.

He also reported that 550 Fellows of the Society had signed as participating physicians, and in addition, the staff of the Truesdale Hospital in Fall River had voted to endorse the program and participate in it.

He reported further that three local insurance authorities had been invited to serve as insurance consultants to the committee.

For the committee Dr. Abbate requested a decision from the House of Delegates relative to the publication of the list of participating physicians.

DISCUSSION . . .

There was brief discussion of the report and of the distinction between a participating and a non-participating physician. At the conclusion of the discussion it was moved that the House of Delegates authorize the Committee on Health Insurance to release to the insurance companies participating in the program, and to the press, if necessary, a list of the participating physicians for the surgical insurance plan. The motion was seconded and passed.

Scientific Work and Annual Meeting:

Dr. Arthur H. Ruggles, chairman of the Committee on Scientific Work and Annual Meeting, reported briefly on the plans for the mid-winter meeting of the Society to be held on Monday, February 2. He also reported that the program for the annual meeting in May was almost complete.

Committee on Medical Examiners:

Dr. B. Earl Clarke presented the report of the joint committee of the Rhode Island Medical Society and the Rhode Island Bar Association relative to the existing laws concerning medical examiners in Rhode Island. Copies of the report were submitted to the members of the House of Delegates and a copy is appended to and made a part of the official minutes of this meeting.

Dr. Clarke moved that the House of Delegates approve the report and submit it to Governor John O. Pastore. The motion was seconded.

Dr. Rocco Abbate questioned the recommendations of the report as not stipulating the duties of the medical examiners. He also criticized the proposal for a central office, citing that such an arrangement would require that all bodies be brought to Providence for autopsies.

Dr. Clarke stated that the reason the committee did not recommend that the medical examiners have final say on performing their own autopsies was because the medical examiners did not wish to assume that responsibility but expressed a preference that it be left to the attorney general's office.

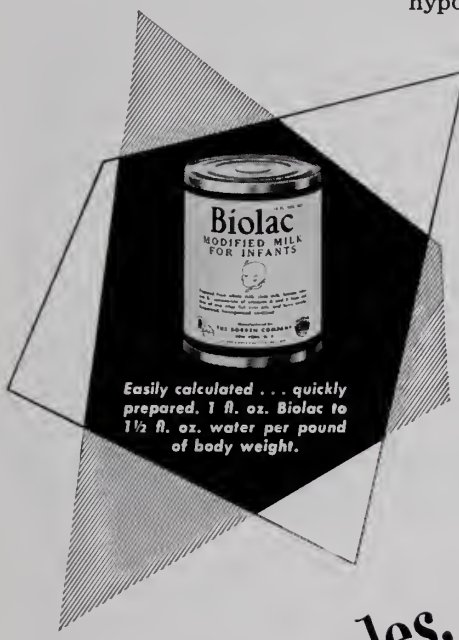
Regarding the central office and post mortem laboratory located in Providence, he stated that in the opinion of the committee a post mortem could be done better in the examiner's own headquarters with the aid of his assistant and facilities there. He also stated that it would be less expensive to transport the body than to take a team of men about the state to conduct the examination.

Dr. Ashworth queried as to what were the reactions of the medical examiners relative to the

continued on page 124

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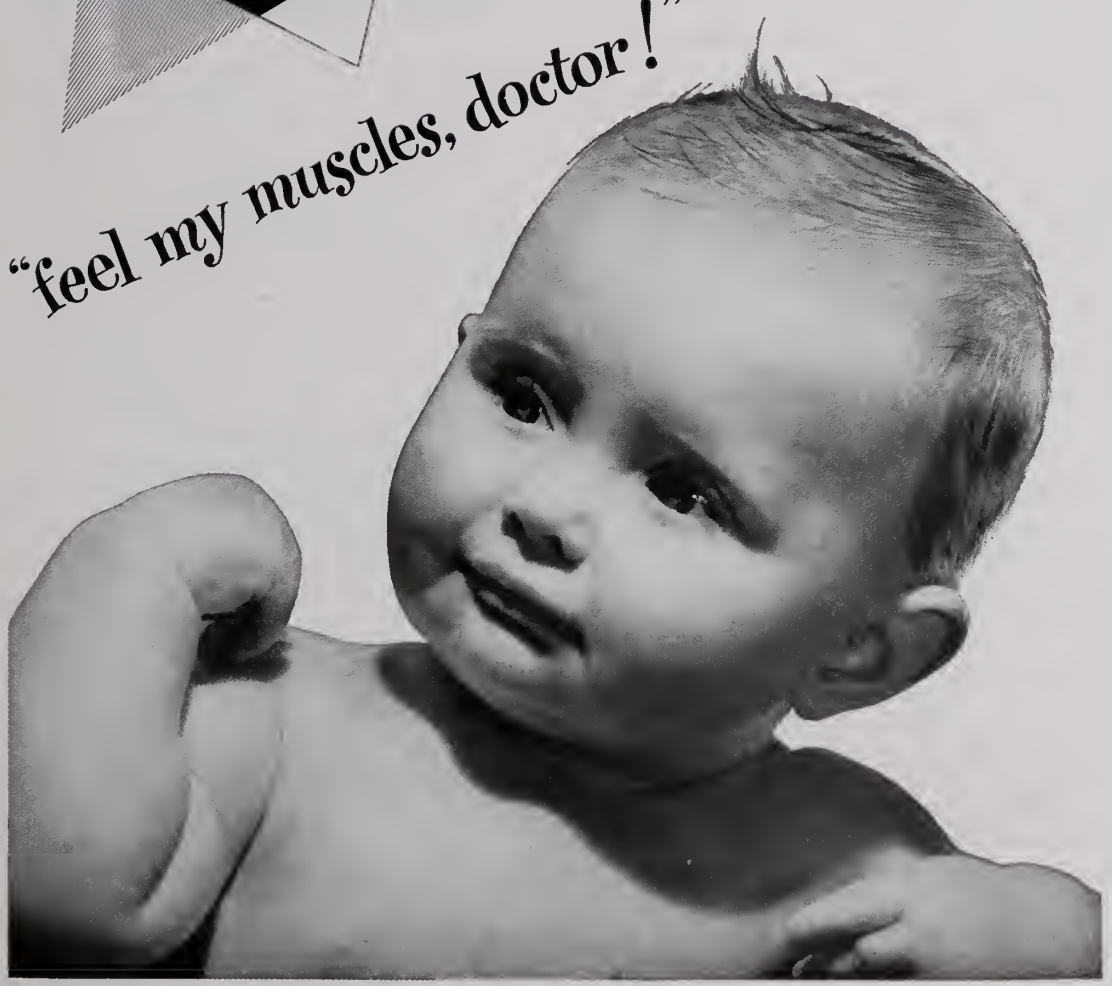
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HOUSE OF DELEGATES MEETING

continued from page 122

problems. Dr. Clarke stated that there was no unanimity of opinion. Some favored a change; others didn't.

Dr. Ruggles called for a decision on the question.

The House of Delegates adopted the motion made by Dr. Clarke to approve the report and submit it to the Governor.

Nominations for Board of Directors of the Blue Cross:

Dr. Ruggles reported the request of the Blue Cross for seven nominees from the Rhode Island Medical Society to serve as members of the board of directors of that organization. He discussed the matter briefly and expressed the opinion that the Society should be actively represented.

There was no discussion, and Dr. Abbate moved that the House renominate as its representatives on the board of directors of the Blue Cross the men who had represented the Society during 1947, as follows: Doctors Samuel Adelson, Philip Batchelder, Edward S. Brackett, William P. Davis, Frank W. Dimmitt, G. Raymond Fox, and Albert H. Jackvony.

The motion was seconded and passed.

Nominations for Committee on Staff Organization of the Veterans Hospital:

Dr. Morgan Cutts, secretary, reported that each hospital except Westerly had submitted three nominees in accordance with the request of the House of Delegates. This request was the result of the action of the House at its November, 1947, meeting to create a state-wide committee representative of the hospitals to aid in the staff organization of the new United States Veterans Hospital in Providence.

Dr. Mara moved that the House ballot on the list of nominees submitted and that the ten highest be named as the committee. The motion was seconded and passed.

The question was raised whether each hospital should be represented or the ten men receiving the most votes. The chair ruled that in accordance with the motion passed the ten men receiving the highest number of votes should form the committee.

The tellers recorded the vote showing one nominee with 17 votes, two with 12 each, four with 10 votes each, and four with 9 votes each.

Dr. Frank Cutts moved that the Committee be expanded to include eleven nominees with the most votes. The motion was seconded and passed.

Dr. Ruggles noted that both he and Dr. David G. Wright of Butler Hospital were included and he stated that he felt that hospital should not have two representatives. Therefore, he withdrew his name and requested that the committee of ten be elected.

At this point Dr. Joseph C. O'Connell called attention to the original motion to establish the committee made at the meeting of the House of Delegates in November, 1947, calling for a committee to be representative of all the hospitals in the state. He moved that the House reconsider the action already taken and that it take a new ballot to carry out the intent of the original motion to provide for representation of each hospital.

Dr. O'Connell's motion was seconded and passed.

A new ballot was recorded and the tellers reported the following with the highest votes:

David G. Wright, M.D., Butler Hospital
Edward A. McLaughlin, M.D.,
Charles V. Chapin Hospital
Walter S. Jones, M.D., Lying-In Hospital
Henry J. Hanley, M.D., Memorial Hospital
Herman P. Grossman, M.D., Miriam Hospital
James C. Callahan, M.D., Newport Hospital
Herman A. Lawson, M.D.,
Rhode Island Hospital
Harry Darrah, M.D.,
Roger Williams General Hospital
Fred Burns, M.D., St. Joseph's Hospital
Charles B. Ceppi, M.D., South County Hospital
Alfred E. King, M.D., Woonsocket Hospital

Dr. Russell R. Hunt moved that the Committee on Staff Organization of the United States Veterans Hospital be a committee of twelve consisting of the eleven members nominated by the House of Delegates in the ballot taken, and to include also a member from the Westerly Hospital to be nominated by that hospital and thereby appointed by the President of the Society.

The motion was seconded and passed.

Report of the Delegate to the A M A:

In the absence of Dr. Herman A. Lawson, Delegate to the House of Delegates of the American Medical Association, Dr. Morgan Cutts read his report of the meeting held at Cleveland on January 5 and 6. He stated that this report was a preliminary one and that the complete report would be published in the RHODE ISLAND MEDICAL JOURNAL at a later date.

Providence Medical Association Centennial:

Dr. Earl Mara, Delegate from the Pawtucket Medical Association, moved that the House of Delegates of the Rhode Island Medical Society extend its felicitations to the Providence Medical Association on the occasion of its centennial celebration. The motion was seconded and unanimously carried.

continued on page 128

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THE RHODE ISLAND MEDICAL EXAMINER SYSTEM

Report of the Joint Committee of the Rhode Island Medical Society and the Rhode Island Bar Association

DURING the past several years the laws relating to medical examiners have frequently become the subject of discussion and there has been expression at various times that these laws were in need of revision. To study the present laws a committee of the Rhode Island Medical Society was appointed. This committee, in turn, requested the assistance of the Rhode Island Bar Association. The bar association appointed its committee to assist in this study and the joint committee has met several times. During its study the joint committee has investigated the cost of the Rhode Island medical examiner system, and has broken down this data into counties for the past three years; determined the number of autopsies held during the past three years; and correlated the existing statutes of this state relative to medical examiners.

It has conferred with numerous medical examiners of the state and given an opportunity to all medical examiners to express their views in favor or in criticism of the existing situation and to make suggestions for improvement in the law. The committee has also considered and discussed written communications from medical examiners of this state.

The committee has conferred with Dr. William Magill, senior of the medical examiners of this state; with Dr. Alan Moritz of the department of legal medicine of the Harvard Medical School, and with a representative of the attorney general's office of this state.

The Committee has abstracted and discussed the laws relating to medical examiners of the states of Virginia, Maryland, New Jersey, Oklahoma and Massachusetts.

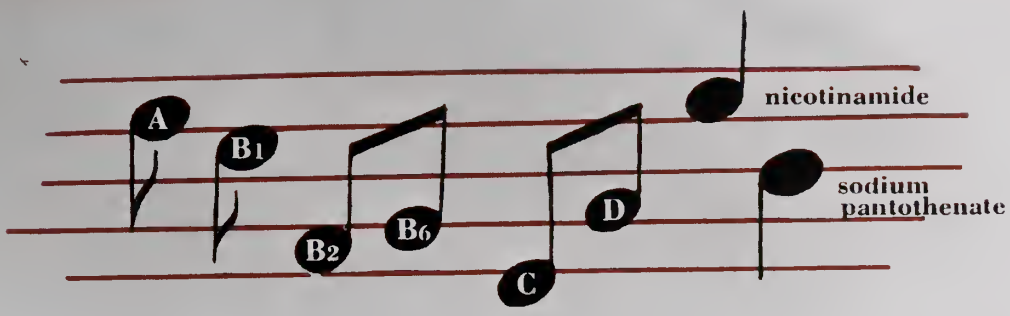
As a result of its study the committee submits the following recommendations. Many details, as for example, the duties of county medical examiners, have not been elaborated — the committee feeling its function to be reviewing the general structure of the law rather than rewriting the statute.

The committee's recommendations are as follows:

1. That there be established the office of chief medical examiner for the state as a full-time position at a salary sufficient to attract a capable person whose duties would include the performing of all autopsies required by law and also acting as state pathologist.
2. That there be an assistant medical examiner appointed by the chief medical examiner to perform the duties of the chief medical examiner in the latter's absence, as for example, during vacation, illness, etc., and that the assistant medical examiner be one of the county medical examiners.
3. That the appointment of the chief medical examiner remain within the department of the attorney general; that he be appointed for a period of six or eight years, subject during his term to removal for cause.
4. That the chief medical examiner, the assistant medical examiner, and the county medical examiners be doctors of medicine, and that the chief be qualified in pathology and have at least one year of medico-legal training.
5. That provision be made for a central office for the chief medical examiner with adequate clerical assistance and a post-mortem laboratory located in the city of Providence.
6. That the chief medical examiner be authorized to call upon and employ, as occasion necessitates, such persons skilled in science or otherwise, as will aid him in the performance of his duties.
7. That there be a reduction in the present number of county medical examiners so as to provide for six county medical examiners for the counties of Providence and Bristol and two for each of the other counties of the state.
8. That county medical examiners be appointed by the chief medical examiner (subject to the approval of the attorney general) and hold office for four years, subject during their terms to removal for cause.
9. That the fees for county medical examiners be revised, so as to provide
   (a) $10 for a view.
   (b) $25 for assisting at an autopsy.
   (c) Travel fees as fixed for other state employees.
10. That the chief medical examiner be not entitled to additional compensation for testifying in court, but that county medical examiners be paid for so testifying, the rate of compensation to be determined by the attorney general.

continued on page 128

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R. I. MEDICAL EXAMINER SYSTEM

continued from page 126

11. That the statute defining the duties of medical examiner be revised along the following lines:

    Upon the death of any person from violence, or suddenly when in apparent good health, or when unattended by a physician, or in any suspicious or unnatural manner, or as the result of an abortion or suspected abortion, the county medical examiner shall be notified by the attending physician, law enforcement officer, undertaker or hospital or by any other person having responsibility for burial or cremation.

12. That where a person dies suddenly on a public highway or elsewhere in the public view from apparent natural cause the removal of such body to an appropriate place may be ordered by any superior police officer as well as by others now having such authority.

As stated above the committee has not attempted to rewrite the law in its entirety. It feels that this is indicated only if its recommendations are approved. The committee has therefore confined itself to a broad consideration of the law and methods for its improvement.

RHODE ISLAND BAR ASSOCIATION
Fred A. Otis, *Chairman*
Peter W. McKiernan
Jacob S. Temkin

RHODE ISLAND MEDICAL SOCIETY
B. Earl Clarke, M.D., *Chairman*
Edward A. McLaughlin, M.D.
William H. Foley, M.D.

HOUSE OF DELEGATES MEETING

concluded from page 124

At the request of the chairman, Dr. Philip Batchelder spoke briefly of the plans of the Association for the observance of its centennial.

The meeting adjourned at 11:20.

Respectfully submitted,
Morgan Cutts, M.D., *Secretary*

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THE WORKMEN'S COMPENSATION LAW

Report of the Committee on Industrial Health of the Rhode Island Medical Society, adopted by the House of Delegates, November 24, 1947

EARLY in the spring of this year the Committee on Industrial Health held meetings with the Chief of the Division of Workmen's Compensation of the Rhode Island Department of Labor, and with representatives of insurance companies writing the bulk of the liability for industrial concerns subject to the law. In both instances the only complaint voiced was that a few doctors (three or four) were seemingly making excessive charges for diathermy treatments.

The Committee for the Society offered to use whatever power it possesses to discipline any of Rhode Island Medical Society members abusing any privileges granted under the Compensation Act, provided evidence was submitted with which to substantiate the accusation against the individual physician. Neither the Chief of the Workmen's Compensation Division nor the insurance company representatives were willing to present concrete evidence to support their complaint. The Committee called to the attention of the Workmen's Compensation Division that it is within the power of the Labor Department of the State to take action if it finds any charges excessive, and called to the attention of the insurance representatives that the Committee was prepared at any time to assist in advising whether a fee charged for service to a beneficiary of the Workmen's Compensation Act is beyond the prevailing fee charged to the Community.

When legislation in the General Assembly was introduced to provide for the creation of a Workmen's Compensation Law Commission, this Committee and also the Committee on Public Laws of the Society, sought without success to have Medical Society representation on the Commission.

Your Committee on Industrial Health notified the Commission that it would like to meet with it, and on October 10, 1947, we were notified that we might have such a meeting, in private session, the first or second week in November, 1947. Ten days later the Chairman of the Commission notified your Committee that a misunderstanding had arisen as a result of an oversight on his part, and that the Society was now invited to testify publicly at a hearing on October 27, 1947. Under the circumstances the Committee prepared a report which was read to the Commission at the hearing and which is published in full in the RHODE ISLAND MEDICAL JOURNAL in the November, 1947, issue. As noted above, the only complaints placed before this Committee have been those relative to fees. Therefore, the Committee rightfully answered that question in the statement to the Commission. Our statement also carefully noted that it was a Committee report offered to aid the Commission, and that the Society would undoubtedly desire to amplify the statement with recommendations for the improvement of the Workmen's Compensation program as regards all its medical phases.

It is unfortunate that the Commission required a public hearing since the Committee therefore had to prepare a statement on the major complaint of which it had been informed by the Chief of the Workmen's Compensation Division and the insurance companies. Had the Commission permitted an informal conference on all the medical phases of the program, pointing out what its study had shown to be faults, or reporting criticisms, then the Committee, in the light of its experience, might have rendered far more valuable service in the exploration of the ways in which to improve the Act. Authorities whose familiarity with the Rhode Island program was in the main statistical, were allowed to draw freely upon unfavorable experiences in other states regarding medical phases of the Workmen's Compensation Act that were not relevant to the situation here in Rhode Island. Consequently, the medical profession has been publicly subjected to editorial comment in the *Providence Journal-Bulletin* within the month that is without factual foundation and thereby does a great injustice to the physicians in Rhode Island.

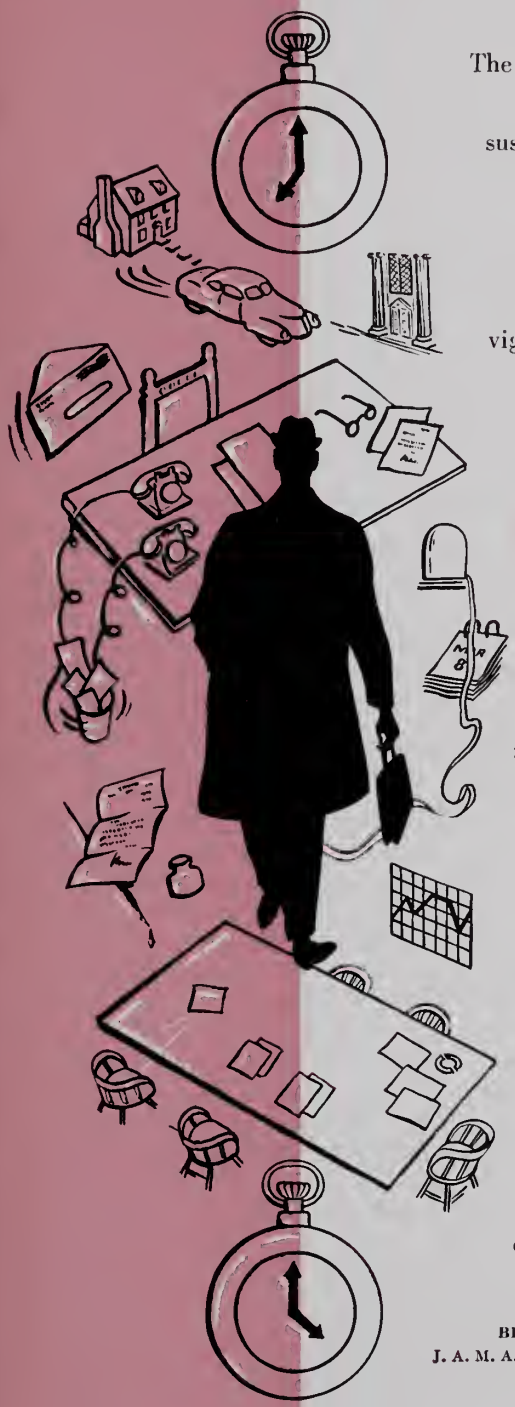
The Committee feels that the Society should contribute in every possible way to the strengthening of the Workmen's Compensation Act — but should in no measure yield in its stand that the best care possible of the injured worker is the paramount issue.

The following recommendations are offered by the Committee for consideration by the House of Delegates:

1. That the Rhode Island Medical Society offer to submit to the Workmen's Compensation

continued on page 132

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BIBLIOGRAPHY: (1) Dunn, C. W., in discussion on Werner, A. A.: J. A. M. A. 127:705, 1945. (2) Dunn, C. W.: Pennsylvania M. J. 45:362, 1942.

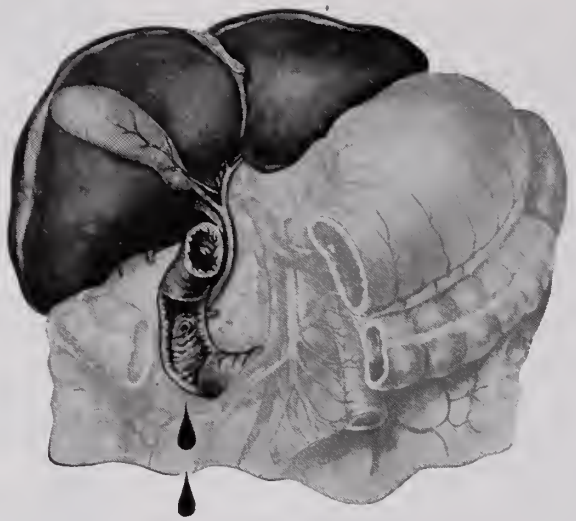
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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.

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WORKMEN'S COMPENSATION LAW

continued from page 130

Agency a list of 75 physicians to be selected by the Society with due regard for the specialties hereinafter named, and that from this list the Workmen's Compensation Agency select as follows:

3 from each of the following specialty groups:

Dermatology	Neuro-psychiatry
Ear, Nose Throat	Neuro-surgery
Eye	Orthopedics
Gynecology	Radiology
Industrial Medicine	Surgery
Internal Medicine	Urology

1 from each of the following specialty groups:

Allergy	Gastroenterology
Cardiology	Obstetrics
Chest diseases	Pathology
Communicable diseases	

and 7 general practitioners.

2. That this list of 50 physicians to be selected from the master list of 75 physicians submitted by the Rhode Island Medical Society be utilized by the Workmen's Compensation Agency as follows:

A. As the impartial Examiners for the Agency. Physicians to be used individually, or in groups of three or more.

B. As personnel for Advisory Boards. Three or more physicians to be selected, with due reference to the specialty care involved, to act at any time on any contested or difficult case coming under the jurisdiction of the agency. It is also recommended that in view of the present situation which provides for compensation for specific injuries by definite added weekly payments or by percentage disability, the Advisory Board be consulted where a reasonable doubt exists as to the fairness of compensation, being allowed to recommend suitable increase in these unusual cases.

C. As personnel for boards of review. The Advisory Boards above mentioned would alone have the authority of review of the medical status of any case and would also have the authority to recommend a change of physician if in their opinion the patient would be better served thereby.

3. That the prevailing rates for medical care be continued, this to include the physicians fees, dental fees, hospital charges, with related personnel and institutional care, and appliance charges.

4. That the occupational disease and personal injuries be better defined in the law, thereby confining compensation payments to those disabilities clearly arising out of and in the course of employment, or peculiar to a particular type of employment.

5. That the Curative Center be made available to physicians for their private patients, other than workmen's compensation cases, and to various social service agencies, on the recommendation of a physician, who are limited in their present scope of personnel and equipment, provided payment is made by such persons or agencies at prevailing rates established by the Curative Center. It is also recommended that the Division of Vocational Rehabilitation and Physical Restoration of the state department of Education share in the cost of use and operation of the Curative Center.

6. That asbestosis and silicosis be eliminated from special consideration in the law, and that they be included with the other occupational diseases.

7. That no changes be made in the present law which includes no differential in compensation costs or payments for dangerous and non-dangerous trades.

8. That consideration be given to the inclusion under the law of government employees, agricultural workers, employees of public utilities, and domestic workers.

9. That more specific reporting following more accurate and careful examination of back injuries be carried out. To achieve this reporting it is recommended that the Workmen's Compensation Agency issue to each physician in the state special report forms covering specific tests to be done in the treatment of a back injury; and further, that it be required that these forms be returned promptly and completely filled out with information giving the results of such tests on examination. It is also recommended that Medical Advisory Boards, as proposed above, be used for counsel and advice on back injury cases.

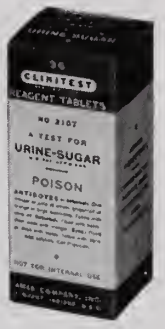
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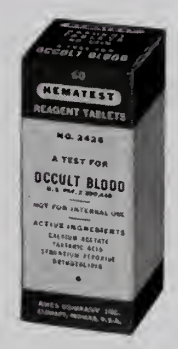
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EIGHTH ANNUAL CONGRESS ON INDUSTRIAL HEALTH

At Cleveland, Ohio, January 5-6, 1948

STANLEY SPRAGUE, M.D.
Chairman, Committee on Industrial Health, R. I. Medical Society

THE MONDAY SESSION of the Eighth Annual Congress on Industrial Health opened promptly at 10 a.m. with the report of the Secretary of the Council on Industrial Health, Dr. Carl M. Peterson of Chicago. His talk was short and to the point, bringing out several items which the Council is at present interested in. The two main principles introduced were the approval of residencies in occupational medicine and secondly, the going over of the revisions of the medical advisory board for the miners groups.

Dr. Arthur J. Vorwald from Saranac Lake, New York, spoke on "Essential Correlations Between Medicine and Industrial Research." His paper was largely didactic and the practical suggestions were very few.

A panel followed this at which Dr. A. J. Lanza presided. Three speakers were given the subject "Health and Welfare in the Ladies' Garment Industry."

Mr. Max Meyer of New York, a member of the New York State Industrial Council, may have intended to speak on the subject of History, but his paper dealt entirely with the socialization of medicine, which he definitely urged.

The two following speakers held very little to their points which were to have been "Present Scope and Procedure," and "Medical and Health Implications." These papers were not heard in their entirety as neither speaker seemed to have any practical solution as was expected.

Monday afternoon Dr. Kenneth C. Peacock, of New York, Chairman of the Committee on Industrial Health for the Medical Society of the County of New York, repeated a paper heard early in 1947 and laid out tentative plans for small plant medical services in and around New York. It was apparent, since I heard him in early May of 1947 that many steps toward the carrying out and instituting of medical services had been installed in many small business plants in New York City.

One of the most colorful, brief and yet pungent talks was given by Dr. Harold M. Harrison, of Toronto, who is Medical Director of George Weston, Ltd., who are packagers and preparers of cooked foods. He really got down to bedrock in treating people as human beings, using a good deal of the so-called old-fashioned psychology which consisted mostly of treating the particular case in hand and accentuating good pats on the back and positive psychology. He was quite amusing in some of his remarks.

The panel which followed this, "How Good Should Industrial Medical Examinations Be?", was probably the most constructive and practical of all the papers heard during this conference. Dr. James R. Miller, of Chicago, who is the Dean of Northwestern University Medical School, was the moderator and he introduced as the discussion leaders Dr. Oscar A. Sander of Milwaukee, an industrial medical consultant, Dr. George H. Gehrmann, of Wilmington, Delaware, medical director of the E. I. du Pont Company, and Dr. William A. Sawyer, of Rochester, medical director of the Eastman Kodak Company.

Each and every one of these speakers stressed physical examinations before employment and stressed the need for medical men to know the jobs for which the particular men were to be employed and said that disabilities should be taken into account and looked at almost entirely from an ability standpoint, rather than to pass every man if he were nearly physically fit and hope for the best. The chest x-ray was accentuated, the blood test was given some consideration, but in the main, the general physical ability of the individual to do the specific job was stressed.

On Monday evening at 6:30 the annual dinner was attended very largely. It was my pleasure to be seated with Dr. Herman A. Lawson, our Rhode Island delegate.

The first speaker of the evening was Mr. Black, who is the President of the Liberty Mutual Insurance Company of Boston. He pointed out the value of getting legislation which would integrate the medical men, the insurer, the employer, and the labor angles and look for greater benefits outside of employment such as hospitalization and so forth

continued on page 136

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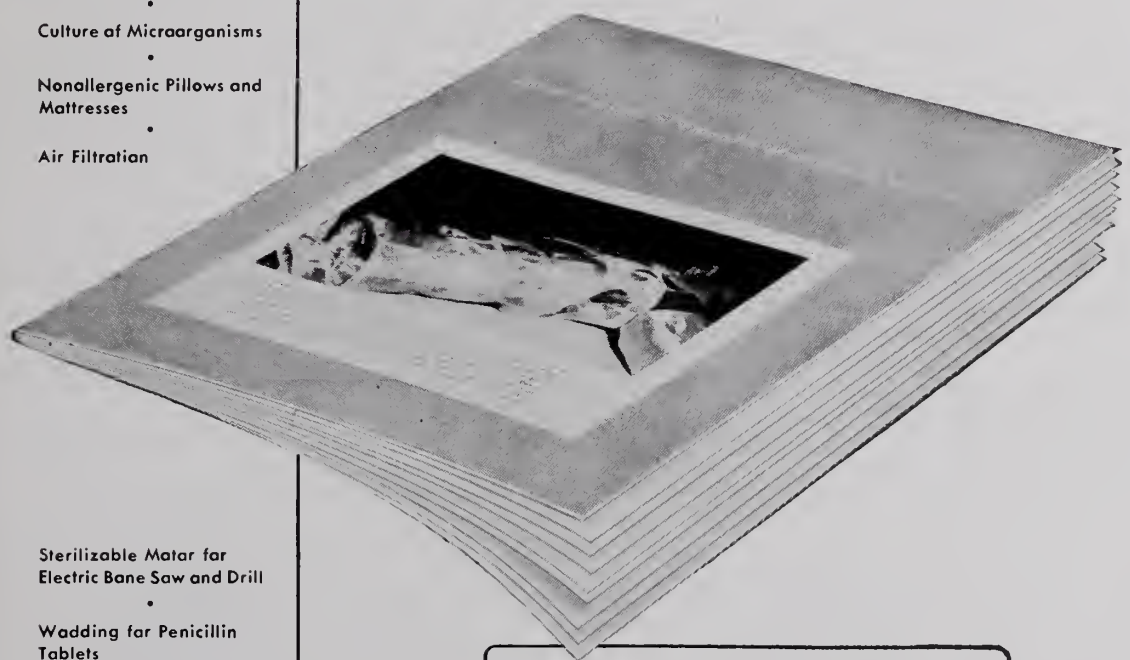
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INDUSTRIAL HEALTH CONGRESS

continued from page 134

for families of the workers, a less insistent attitude on increased benefits by union leaders, a greater interest by more physicians in the various problems of industrial health and accident prevention, and he further stressed the cooperative attitude which he felt insurance companies must have in protecting employers as well as employees either in accident or in health conditions. .

Dr. Howard A. Rusk, of New York, who is chairman of the department of rehabilitation in medicine in the New York University College of Medicine, gave a most dramatic and factful address on exactly what was being done in rehabilitation of all types of patients. He presented one man as an example, and this man's speech, though brief, was very effective and was well received by the gathering. He was originally a lawyer in Missouri and was stricken with polio, was totally paralyzed below the waist and 80 percent paralyzed in both arms, and yet today he has been able to overcome a great deal of his upper body paralysis so that he may do many practical things for his own welfare, and it was stated that this man had been given a new position in New York as a lawyer with a firm of well-known lawyers and here he has full charge of legal matters pertaining to the oil companies.

The last speaker of the evening was the assistant medical director of the Eastman Kodak Company who was with the "Operations Crossroads." He described the use of the camera in the taking of all the beautiful pictures which he later showed for this operation which took place at Bikini.

On Tuesday morning at nine there was a conference on respiratory infections. Dr. M. V. Veldee, of the biologic control laboratory, National Institute of Health, spoke on "Virus Vaccines — A Review and Evaluation." The impression remained with me that there is very little definitely known so far about how far these virus infections can be controlled by any present commercial vaccine. It was pointed out during discussion afterward that the type of influenza germ recently the cause of an epidemic in Los Angeles was a slightly different type than any so far contained in any of the present vaccines.

Several of the audience tried to get him to definitely give an opinion as to whether or not people should be inoculated now, or if not now, when, to protect them from influenza conditions. The answers received were very vague and left it up to the individual doctor to do as he saw fit.

The second speaker was Dr. Alvan L. Barach, of New York, associate professor of clinical medicine, College of Physicians and Surgeons, Columbia University. He gave a very definite talk on "Aerosol Therapy in General and in Industrial Practice." He illustrated with slides of varying types of inhaling apparati that are being sponsored at Columbia and spoke very favorably of the action of Aerosol with or without penicillin taken orally or intramuscularly in the treatment of many deep-seated, acute and chronic sinuses and bronchial conditions. His paper was very well received and many questions were afterward discussed.

At eleven o'clock Tuesday morning the conference on the outlook for industrial medical service met under the leadership of Dr. Paul B. Magnuson, of Washington, D. C., who is the acting assistant medical director for professional services of the Veterans Administration.

The first speaker was the President-Elect of the American Medical Association, Dr. R. L. Sensenich. He generalized on the subject of industrial medicine and industrial physicians and his closing remarks were that the best physician for everyone concerned at the present time is the family physician.

Dr. Herman G. Weiskotten, of Syracuse, Chairman of the Council on Medical Education and Hospitals of the American Medical Association, gave a rather rambling and legislative talk on making a specialty of industrial medicine as one of the group of specialties recognized by the A M A. It was apparent from his talk that no great amount of attention was to be paid to this practice as a specialty for a long while to come because of the variance of the types of industry in which different doctors were employed.

Dr. James R. McVay, of Kansas City, Missouri, Chairman of the Council on Medical Service of the American Medical Association, followed him with a discussion of what the A M A medical services are and might be.

Tuesday afternoon I anticipated an excellent conference on occupational cancer. Dr. Shields Warren, of Boston, presided and spoke of many

continued on page 138

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CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.

INDUSTRIAL HEALTH CONGRESS

continued from page 136

of the pathologic aspects which occupational cancer takes. His talk was brief and he introduced Dr. William T. Salter, of New Haven, who spoke on "Clinical Aspects." This paper lasted a full hour and was a masterful discussion of organic chemistry. Its application for practical purposes was nil.

Dr. W. C. Heuper, of New York, followed with the clinical aspects. This paper I regret to say I was unable to stay for due to train schedules. It will, however, be published.

In making this report I would call attention to the fact that there were a tremendous number of doctors present at this conference. The ballroom used for the first meeting was well over half filled and the group broke up into varying rooms for the different subjects.

The Committee on Arrangements was most definitely courteous and obliging. The scientific as well as the commercial exhibits were very fine. I do feel that Dr. Peterson as Secretary of the A M A Council on Industrial Health deserves a word of extreme commendation for his arrangements. It is also felt that the fact that the A M A House of Delegates met at the Hotel Statler had a beneficial action on the presence of such a large number.

There were several papers which could not be heard due to the concomitant recital. Particularly would I like to have heard "The Physiology of the Bone Marrow in Relation to Industrial Intoxication." I would like to have heard some of the papers on nutrition, and certainly I regret missing the paper, "Correlating Rehabilitation and Industrial Practice."

In all, the conference was extremely interesting and while I do not feel that too much of the practical was heard, there certainly was a sufficiency of theoretic and didactic materials presented and it is probable that your delegate did not entirely appreciate their value.

Very little was mentioned about Workmen's Compensation, and the personal touch such as was exhibited in Boston last year was entirely missing. Dr. Hennessey, the assistant to Dr. Peterson, was very cordial and he was very much interested in the new surgical plan suggested by the Rhode Island House of Delegates and was very much interested to hear about the action of the Rhode Island Industrial Health Committee in their suggestions to the Rhode Island Workmen's Compensation Commission.





double deficiency

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1. Vaux, H. W., and Rakoff, A. E.: Am. J. Obst. & Gynec., 50:353, Oct. 1945.
2. Zondek, B.: J.A.M.A., 118:705, Feb. 28, 1942.

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PROVIDENCE MEDICAL ASSOCIATION

Report of 101st Annual Meeting

THE one hundred and first annual meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, January 5, 1948. The meeting was called to order by the President, Dr. Guy W. Wells, at 8:30 p.m.

The reading of the minutes of the previous meeting of the association was omitted.

Dr. Daniel V. Troppoli read the annual report of the secretary for 1947. It was moved, seconded and passed that the annual report of the secretary be accepted and placed on file.

Dr. J. Murray Beardsley read the annual report of the treasurer for 1947. It was moved, seconded and passed that the annual report of the treasurer be accepted and placed on file.

Dr. Guy W. Wells delivered his presidential address, in which he reviewed the development of medical science in the past century and also discussed the development of early medical societies, referring particularly to the sound origin and development of the Providence Medical Association.

The President called for the nominations for officers for 1948. Dr. Daniel V. Troppoli read the slate of nominees proposed by the Executive Committee which read as follows:

President:	Philip Batchelder, M.D.
Vice President:	George W. Waterman, M.D.
Secretary:	Daniel V. Troppoli, M.D.
Treasurer:	J. Murray Beardsley, M.D.
Executive Committee	Guy W. Wells, M.D. Herman A. Lawson, M.D.
	(2 members for 3-year terms)
Trustee of R. I. Medical Library	Frank B. Cutts, M.D.

Delegates:

Robert Baldridge, M.D.	Donald DeNyse, M.D.
Philip Batchelder, M.D.	David Freedman, M.D.
J. Murray Beardsley, M.D.	Peter F. Harrington, M.D.
Alex M. Burgess, M.D.	William A. Horan, M.D.
Peter Pineo Chase, M.D.	Russell R. Hunt, M.D.
B. Earl Clarke, M.D.	Albert H. Jackvony, M.D.
Paul C. Cook, M.D.	Walter S. Jones, M.D.
G. Edward Crane, M.D.	Louis I. Kramer, M.D.
Frank B. Cutts, M.D.	Herman A. Lawson, M.D.
William P. Davis, M.D.	Edward A. McLaughlin, M.D.
John C. Myrick, M.D.	Daniel V. Troppoli, M.D.
Michael J. O'Connor, M.D.	George W. Waterman, M.D.
Edwin B. O'Reilly, M.D.	Frederick A. Webster, M.D.
Patrick I. O'Rourke, M.D.	Guy W. Wells, M.D.

He reported that no counternominations had been submitted to him. It was moved, seconded and unanimously passed that the slate of nominees submitted by the Executive Committee be deemed official as the officers of the association for 1948.

Dr. Guy W. Wells nominated a committee of Dr. George W. Waterman and Dr. Edward S. Cameron to escort the new President, Dr. Philip Batchelder, to the rostrum.

Dr. Batchelder expressed his appreciation to the members for the honor bestowed on him and he asked the support and assistance of every member in the promotion of the interests of the association during 1948. He also expressed the hope that it will be possible to re-establish the custom of presenting a case report at the beginning of each of the season's meetings of the association.

Dr. Batchelder reported that the roster of committees to serve during 1948 will be published in the RHODE ISLAND MEDICAL JOURNAL. He also

continued on page 142



PHILIP BATCHELDER, M.D.
President, 1948
The Providence Medical Association

44...

OF NEMBUTAL'S CLINICAL USES

SEDATIVE

Cardiovascular
Hypertension[1]
Coronary disease[1]
Angina[1]
Decompensation
Peripheral vascular disease

Endocrine Disturbances
Hyperthyroid
Menopause—female, male

Nausea and Vomiting
Functional or organic disease (acute gastrointestinal and emotional)
X-ray sickness
Pregnancy
Motion sickness

Gastrointestinal Disorders
Cardiospasm[2]
Pylorospasm[2]
Spasm of biliary tract[2]
Spasm of colon[2]
Peptic ulcer[2]
Colitis[2]
Biliary dyskinesia

Allergic Disorders
Irritability
To combat stimulation of ephedrine alone, etc.[3,4]

Irritability Associated With Infections[4]

Restlessness and Irritability With Pain[5,4]

Central Nervous System
Paralysis agitans
Chorea
Hysteria
Delirium tremens
Mania

Anticonvulsant
Traumatic
Tetanus
Strychnine
Eclampsia
Status epilepticus
Anesthesia

HYPNOTIC
Induction of Sleep

OBSTETRICAL
Nausea and Vomiting
Eclampsia
Amnesia and Analgesia[6]

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Basal Anesthesia
Postoperative Sedation

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Blood transfusions
Administration of parenteral fluids
Reactions to immunization procedures
Minor surgery

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PROVIDENCE MEDICAL ASSOCIATION MEETING

continued from page 140

announced that the annual reports for 1947 would be published in the medical journal and therefore would not be read at the meeting.

Dr. Troppoli reported for the Executive Committee as follows:

The Executive Committee has approved of the budget for the operation of the association during 1948 of $6,827. To meet this budget the committee recommends that the annual assessment for 1948 be $15 for active members and $5 for associate members.

A motion was made from the floor, seconded and passed that the budget as reported be accepted and that the annual assessment as proposed be established for 1948.

The secretary reported that the Executive Committee recommends for election to active membership in the association William C. Howrie, Jr., M.D., of 252 George Street, Providence.

It was moved, seconded and unanimously passed that Dr. Howrie be elected to active membership.

The President made the following announcements:

1. Within the next ten days the members of the association will receive a notice of the Centennial Day observance, to be held on Saturday, January 31. There will be an address at the medical library at 4:30 p.m., by Dr. Reginald Fitz of Boston on the history of the association. Afterwards a social hour, to be followed by dinner, will be held at the Sheraton-Biltmore Hotel. Members are urged to acknowledge the invitation for reservations for the dinner promptly.

2. On Monday, February 2, the association will meet jointly with the Rhode Island Medical Society. The two topics chosen for discussion at this meeting are: "Hospital Economic Problems with Special Reference to Intern, Resident and Staff Appointments," and "The Position of the General Practitioner Today."

Outstanding guest speakers will address the members on both subjects.

The business meeting completed, Dr. Batchelder introduced the speaker of the evening, Dr. Samuel Levine of Boston, who spoke on the topic "Extra-Mural and Intra-Mural Practice; Then and Now."

Dr. Levine stated that one hundred years ago there was a tremendous difference in the role of the practitioner of medicine as compared to that of today. All he could do could be done in the patient's home and in his office. That is all changed now. "The New England Medical Journal" of 1848 was then called "The Boston Medical and Surgical Journal." Most of the articles at that time were on infectious diseases, midwifery and

accidents. There were many discussions on ether, the new drug of that era.

One interesting article was on the treatment of rattle-snake poisoning. Blistering was used for typhus fever. Different drugs for different pains of dysentery were used. All that was known of medicine was therefore done at home or in the office. There was little use for hospitals except for a place to isolate cases — usually from ships — and an alms house to care for the poor.

What simple things can we do to guide us now in correct diagnoses and treatment? Hospital training, with all its laboratory work and x-rays, is quite different from outside practice. In hospitals diagnoses are automatically made for you by the routine tests. This is a bad habit to get into because you cannot do that kind of thinking when you leave the hospital.

On the outside we have to think of all the diseases ruled out by tests in the hospital in our differential diagnosis. We have to make shortcuts which narrow down the field of the panorama of possibilities of diagnosis. Do the right test first and save the patient time and money. A simple clinical finding that costs nothing and is quick and inexpensive is what you want in diagnosis. That is if a patient can walk briskly in cold weather, he does not have angin pectoris — if the pale patient has a furred tongue ,he does not have pernicous anemia. Also, a patient with cardiac enlargement cannot have Addison's Disease.

In making these inexpensive diagnosis, we keep open the hospital beds for those more urgently in need of them. We need the hospital when we can't make a diagnosis with our simple methods used intelligently. However, the better we employ the simple methods extramurally, the less we need the hospital. Any sacrifice is indicated when you are looking for something you could cure.

We should keep asking ourselves what can we do to be helpful, what are we overlooking that can be helped.

It is more important to think of rare diseases that are curable than common diseases that are not curable. The responsibility of the physician today is tremendous as compared to the ones of one hundred years ago.

The meeting adjourned at 10:15 p.m.

Attendance 116.

Collation was served.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D., *Secretary*

NEWPORT COUNTY SOCIETY

A meeting of the Newport County Medical Society was held at the Newport Hospital on Tuesday evening, December 30, 1947.

The meeting was presided over by Dr. Alfred M. Tartaglino, who presented Dr. Jay Rice Moody,

continued on next page

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who in turn showed a group of color motion pictures relating to several of the activities which had taken place under the sponsorship of the Gay Nineties Committee in Newport during the past several years. The pictures included scenes from the parades held on the last two Labor Days, scenes taken during the pilgrimage to Colonial Newport, pictures of the yacht races held in Newport harbor in the lower bay, and photographs of many of the buildings of historic interest in and about Newport.

Following the presentation Dr. Moody was given a rising vote of thanks.

The application of Dr. Eugene Tartaglino for membership in the Society was then received and he was elected to membership.

Dr. Samuel Adelson then discussed the present status of the Prepayment Surgical Plan and stated that several insurance companies are now ready to offer for sale policies which have been approved by the State Medical Society.

Following adjournment a collation was served.

Respectfully submitted,
HENRY W. BROWNELL, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held January 15, 1948, at 9:00 p.m. in the Nurses' Auditorium of the Memorial Hospital.

The President, Dr. Earl Mara, called the meeting to order and the minutes of the previous meeting were read by the Secretary. They were accepted as read.

Dr. Mara announced the opening of a new Thoracic Clinic at the Memorial Hospital which would be directed by the speaker of the evening, Dr. Joseph Corsello. Before his main discussion Dr. Corsello spoke briefly about the new clinic, stating that it would not run in competition with the established Tuberculosis Clinics and that the main interest was primarily in non-tuberculosis chest conditions. However, it would function as a pneumothorax refill clinic for Pawtucket and the immediate vicinity.

The topic for the evening was "Diagnosis of Primary Carcinoma of the Lung." Dr. Corsello illustrated his remarks with a series of lantern slides and later answered numerous queries from the floor.

The meeting adjourned at 10:45 p.m. Twenty members attended.

Respectfully submitted,
KIERAN W. HENNESSEY, M.D.
Secretary



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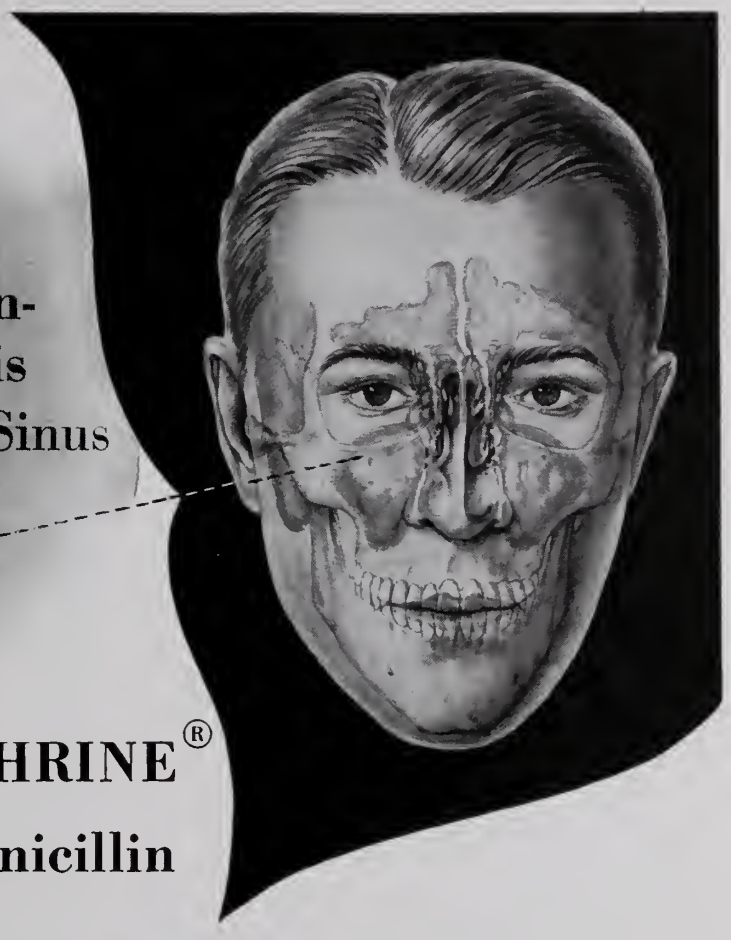
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ANNUAL REPORTS FOR 1947

PROVIDENCE MEDICAL ASSOCIATION

ANNUAL REPORT OF THE SECRETARY — 1947

The Providence Medical Association held eight scientific assemblies during 1947. The February meeting was a joint meeting with the Rhode Island Medical Society. Attendance at the meetings averaged ninety-six members. The topics presented and the speakers of the meetings were as follows:

January 6—Presidential Address. Paul C. Cook, M.D. "Rhode Island's Water Pollution Problem." Panel discussion conducted by Alex M. Burgess, M.D., "Residency and Fellowship Program at the Rhode Island Hospital," Charles L. York, M.D., Herbert F. Hager, M.D., Michael DiMaio, M.D., Wilbur Mantner, M.D. and William J. H. Fischer, M.D., participating.

February 3—"The Role of the General Practitioner in the Early Diagnosis of Pelvic Cancer." Lewis C. Scheffey, M.D., of Philadelphia. "The Diagnosis and Treatment of Liver Disease, with Special Reference to Liver Biopsies." Chester M. Jones, M.D., of Boston.

March 3—"Certain Phases of Water-Borne Infections." Charles A. Stuart, Ph.D., Professor of Biology, Brown University. "Water Pollution Control." Arthur D. Weston, of Boston.

April 7—"Hormonal Alteration of Carcinoma of the Breast." Ira T. Nathanson, M.D. "Lymphatic Spread of Carcinoma and Its Management." Grantley Walder Taylor, M.D., of Boston.

May 5—"The Newer Knowledge of Viruses." Raymond M. Young, Ph.D., Bacteriologist at Rhode Island Hospital. "Clinical Aspects of Certain Functional Disorders of the Biliary Tract," Russell S. Bray, M.D.

October 6—"The German Medical War Crimes." Cortez F. Enloe, Jr., M.D., of New York City.

November 3—"The Characteristics of Asthma in Infancy." William P. Buffum, M.D. Discussant, Stanley Freedman, M.D. "Pathology of Allergic Reaction to Sulfonamides in a Child." Melbourne Brunett, M.D., Robert J. Williams, M.D.

December 1—"The Use of a Low Sodium Diet in Hypertension and Congestive Heart Failure." Michael DiMaio, M.D. "Carcinoma of the Cervix its Prophylaxis Early Diagnosis and Treatment." George Waterman, M.D.

The total members of the Association at the end of the year was 591, of whom 550 are active members and 41 are associate members. At five meetings of the Executive Committee held during the year, a total of fifteen physicians were recommended for election to active membership, eight were granted leaves of absence for postgraduate work, three resignations were accepted of men moving out of the state, one member returning to Providence was reinstated, and fourteen members were approved for associate members.

During the year the following members of the Association died:

Hampartzum S. Gulesserian (January 3)
Harlan P. Abbott (February 2)
Bertram H. Buxton (February 9)
Salvatore Castallo (March 18)
Charles M. Collins (May 9)
Victor P. Rego (June 25)
Jay Perkins (October 18)
William H. McLaughlin (December 7)
George V. Coleman (December 10)

Among the most important actions taken by the Executive Committee during the year was the revival of the house officers Prize Case Report Contest, the development of plans for the Centennial observance of the Association, a study of fees paid by insurance companies for the examination of subscribers, a study of the parking adjacent to physicians offices in the east side area, recommendation of legislation for better sanitation in eating establishments in the city, a study of the free day of the members for the purpose of compiling lists to aid the public, endorsement of the state medical society's prepaid surgical insurance program, and support of the essay contest of the American Association of Physicians and Surgeons.

In 1947 the Rhode Island Medical Society approved of the formation of the Bristol County Medical Society as a district unit. Previously the Bristol County physicians had been affiliated with our Association. It is with pleasure that we report that the majority of these physicians have accepted Associate membership with the Providence Medical Association.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D., *Secretary*

January 5, 1948

ANNUAL REPORT OF THE TREASURER, 1947

RECEIPTS:

Cash on hand, January 1, 1947	$ 664.00	
Membership dues (including 1946 outstanding assessments and two 1948 payments)	7,566.86	
Dividends from investments	22.50	
Annual dinner payments	20.00	
Total		$8,273.81
Receipts	$8,273.81	
Expenses	7,177.09	
Cash Balance (Jan. 1, 1948)		1,096.72
U. S. War Bonds		2,740.00
Total Assets, Jan. 1, 1948		$3,836.72

EXPENDITURES:

Committees	$ 150.00
Collations	467.50
Journals (new, and binding of old)	501.10
Meetings expenses	81.17
General expenses	954.30
Postage	107.94

Printing	280.45
Supplies and equipment	105.64
Refunds (Bristol County members, and Entertainment Committee)	80.00
R. I. Medical Society (Appropriations)	2,148.08
(Use of Library, etc.)	
Salary	1,684.80
Taxes (withholding and social security)	437.76
Telephone	178.35
Total	$7,177.09

J. Murray Beardsley, M.D., *Treasurer*

January 5, 1948

AIR POLLUTION

A new City ordinance for Air Pollution Regulation was approved by the City Council on January 17, 1947. A new air pollution regulation engineer and three assistants within the Department of the Public Service Engineer have been appointed as required by the ordinance. Also, as required, an Advisory Board and an Appeal Board of five members each, have been appointed. The law requires that at least one Doctor of Medicine be included in the membership of each board. Dr. E. S. Cameron and Dr. B. E. Clarke have been made members of the Advisory and Appeal Boards respectively. Members of these two boards receive no remuneration.

The City of Providence now has a good modern Air Pollution Ordinance, but conditions to date are not quite so ideal in Providence as pictured in an article appearing in the September issue of the American City Magazine. We may expect further improvement in the near future as the new appointees within the Department of Public Service become more familiar with the work. Because of the present oil shortage more coal is being burned and this makes the control of air pollution by smoke more difficult.

Members of this association may secure copies of the New Ordinance on Air Pollution Regulation by phoning or writing City Hall. Those who observe persistent violations may help the cause by reporting such violations to Mr. Joseph M. Santoro, Air Pollution Regulation Engineer. The problem involves all of us.

Respectfully submitted,

Edward S. Cameron, M.D., *Chairman*
Frank M. Adams, M.D.
Alex M. Burgess, M.D.
B. Earl Clarke, M.D.
Anthony Corvese, M.D.

ADVISORY COMMITTEE TO THE COMMUNITY WORKSHOPS

During 1947 there has been one meeting of the full committee at which matters of importance to the Community Workshops were discussed and recommendations made. The Executive Committee of the Community Workshops has consulted the chairman of your committee on occasion, and members of your committee have assisted the Community Workshops in a number of matters which did not require concerted action.

Clifton B. Leech, M.D., *Chairman*
Raymond F. Hacking, M.D.
William A. Horan, M.D.
Louis B. Sage, M.D.
Nathan A. Bolotow, M.D.
Catherine Zouraboff, M.D.
John Langdon, M.D.

continued on page 149

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Certified Milk Deserves Your Recommendation

REPORT OF THE MILK COMMISSION OF THE PROVIDENCE MEDICAL ASSOCIATION 1947

Certified Milk in Providence during 1947 was obtained from the following farms: Cherry Hill Farm, North Beverly, Mass.; Fairoaks Farm, Lincoln, R. I.; Hampshire Hills Farm, Wilton, N. H.; Walker-Gordon Farm, Charles River, Mass.

Through the courtesy and co-operation of the Boston Commission we have accepted their certification of two farms from Massachusetts and one from New Hampshire.

Bacteriological and chemical examinations of certified milk are made in the laboratories of Brown University under the supervision of Professor Charles Stuart.

All of the herds are under State and Federal supervision and are free from Tuberculosis and Brucella abortus infections.

Much credit is due the management of these farms in keeping the standards of Certified milk on a high plane and these high ideals have been realized in spite of the acute shortages in materials and labor.

On August 19, 1946, the City Council of Providence approved two additional rules governing the sale of milk in Providence. Rule 12 applies to the sale of raw milk which has a bacteria count of less than 10,000 colonies per cubic centimeter as an average bacteria count of any four consecutive samples examined by the Inspector of Milk using methods set forth in the current edition of "Standard Methods of Milk Analysis" of the American Public Health Association, and unless such raw milk be produced from cows that are certified to be free from Bang's Disease, Tuberbulosis and Mastitis by a licensed Veterinarian at such intervals as the Inspector of Milk shall deem necessary for the protection of the milk consuming public.

The above standards are those set forth in "Methods and Standards" published by the American Association of Medical Milk Commissions and these requirements are enforced by this Commission. We are happy to say that all raw Certified Milk sold in this area for many years has met these requirements and much credit is due to the Certified Farms in meeting these rigid tests.

During the past year the Commission has carried one-half page advertisements in the R. I. Medical Journal in an attempt to keep the "Quality Milk" before the medical profession.

The Commission is indebted to Professors Wilson and Stuart of Brown University for their continued cooperation in supervising our laboratory work at Brown University.

Harold G. Calder, M.D., *Chairman*
Thomas J. Dolan, M.D.
John Langdon, M.D.
Frank Matteo, M.D.
William P. Shields, M.D.
Henry E. Utter, M.D.
George E. Bowles, M.D.
Reuben C. Bates, M.D., *Secretary*

MONTHLY AVERAGES OF CERTIFIED MILK FOR 1947

	CHERRY HILL H. P. HOOD			FAIROAKS						HAMPSHIRE HILLS			WALKER-GORDON		
	Pasteurized			Raw			Pasteurized			Pasteurized			Vit. D. Pasteurized		
	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.
January	3.9	12.35	39	4.2	12.95	5,172	3.9	12.56	80	4.1	12.66	149	3.9	12.59	44
February	3.8	12.17	44	4.1	13.00	4,478	3.8	12.55	231	4.1	12.70	185	3.9	12.58	134
March	3.8	12.15	72	4.1	12.92	4,356	3.7	12.37	156	4.3	12.81	181	4.0	12.73	109
April	3.9	12.31	78	3.9	12.38	4,666	3.8	12.39	113	4.3	12.96	195	3.9	12.56	164
May	3.9	12.42	30	4.1	12.96	5,388	3.8	12.62	133	4.1	12.63	82	3.9	12.63	149
June	3.8	12.32	33	4.2	12.85	8,735	3.9	12.59	44	3.8	12.39	43	3.8	12.38	160
July	3.8	12.33	49	4.3	12.70	18,033	3.9	12.45	116	3.8	12.59	111	3.9	12.50	121
August	3.9	12.58	53	4.2	13.07	5,290	4.1	12.84	352	3.9	12.66	85	3.9	12.39	65
September	4.1	12.74	96	4.2	13.00	5,122	3.8	12.20	281	3.9	12.73	161	4.1	12.62	87
October	4.0	12.62	28	3.9	12.42	4,011	3.8	12.29	98	4.1	12.70	51	4.1	12.64	35
November	4.1	12.52	25	4.0	12.75	3,614	3.8	12.40	128	4.2	12.97	65	3.9	12.46	27
December	4.0	12.69	31	4.4	13.32	2,725	3.9	12.64	27	4.3	13.27	34	4.0	12.65	18
Yearly Average	3.9	12.43	47	4.1	12.86	5,965	3.8	12.49	146	4.0	12.75	112	3.9	12.56	93

ANNUAL REPORTS FOR 1947

continued from page 147

ENTERTAINMENT

The Committee on Entertainment has arranged and provided for the collation following each regular meeting of the Association. It is particularly grateful to our executive secretary, Mr. John E. Farrell, for attending to the details of this function.

It is happy to report that the annual dinner and golf tournament was held at the Agawam Hunt on Wednesday, September 17, 1947. A record attendance of members and their guests was registered at the links as well as at the dinner. The President's Cup was awarded by our president, Dr. Guy W. Wells, to Dr. William J. H. Fischer, Jr., for low net score in the Bankers' tournament.

Many members who attended the dinner were recipients of valuable and attractive door prizes. The performance of a professional entertainer was received with considerable enthusiasm and enjoyment. All comment received by your committee was most favorable.

HERMAN P. GROSSMAN, M.D., *Chairman*
NATHAN BOLOTOW, M.D.
RALPH DILEONE, M.D.
CARL D. SAWYER, M.D.

LEGISLATION

Early in 1947, the chairman of your committee and Mr. Farrell met with Mayor Roberts to express our interest in matters concerning medicine and health. Through his cooperation and that of the City Clerk, Mr. Whelan, we have been kept informed regarding any contemplated city legislation which pertains to medicine or public health.

The subject in which we have been chiefly interested has been the matter of restaurant sanitation, and considerable data on this subject was gathered through correspondence with various public health authorities. A model ordinance was obtained and presented to the committee of the Providence City Council appointed to consider the problem of restaurant sanitation. This committee approved and recommended the ordinance we presented. We also met with members of the Rhode Island Restaurant Association and discussed the proposed ordinance with them.

We have subsequently learned, however, that the licensing of restaurants is in the hands of the Bureau of Police and Fire, and therefore the proposed ordinance would be invalid and impossible to enforce. It is proposed that at the next meeting of the General Assembly, the City Solicitor will request the passage of a law which will invest the power of supervising and regulating restaurants in the Superintendet of Health, and, following this, the model ordinance proposed can be rationally passed by the City Council. We hope to be able to follow this procedure through to its desired conclusion.

Respectfully submitted,

FRANK B. CUTTS, M.D., *Chairman*
ALBERT H. JACKVONY, M.D.
HENRY S. JOYCE, M.D.
ANTHONY V. MIGLIACCIO, M.D.
JAMES H. FAGAN, M.D.

PRE-SCHOOL EXAMINATIONS

The Rhode Island Congress of Parents and Teachers continues its efforts to conduct an effective pre-school examination as part of its health program according to Mrs. Kenneth A. Scott, Health and Summer Round-Up Chairman. The final reports from the various units have been tabulated and there will be an evaluation of the results. The figures for 1947 in both the number of children examined and number of units participating are lower than in 1946.

Providence made a rather elaborate effort on summer round-up in the spring of 1946. Meetings were held which were addressed by principals and others. They were advertised to parents but the results were disappointing. This spring members of the Parent-Teacher Associations were provided with names and addresses of the potential school entrants. "Each local Kindergarten teacher carries on her own program in which she attempts to interest the mothers of the children in her neighborhood."

"Only 17 units completed the final phase of the Round-Up by returning their report blanks, although 28 units sent in applications. However, we find that although we have only 17 units compared to 30 units a year ago, we have examined just over 100 less children than a year ago. This means that each unit did more work and this year cared for 21 plus children compared to 15 plus children last year. It is interesting to note that approximately three-fourths of all children examined in spring Round-Ups had been vaccinated and immunized against diphtheria.

Our conclusions are therefore as follows: although fewer units conducted a Round-Up each one did do a better job than before, particularly when done as a group Round-Up. These are conducted as examining Round-Ups only and children are referred to their family physician for immunization, vaccination and the correction of any physical defects.

The Parent-Teacher organization is very grateful to the physicians who assisted the Units in their communities in conducting a successful Round-Up and in the various radio talks to publicize health examinations."

continued on next page



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School districts participated as follows: Cranston, Glocester, Jamestown, Portsmouth, Providence, Smithfield, Warwick. No doubt there were others in which examinations were conducted but perhaps not reported. There were a total of 385 children examined.

"An advisory health committee has been formed to assist Mrs. Scott in planning the health activities. The committee includes Miss Elizabeth Smith, Supervisor of Public Assistance in Rhode Island; Dr. Gertrude Muller of the Child Guidance Clinic; Mrs. Frank Collaci, a nurse and health chairman for Providence Council last year; Dr. John Langdon, Providence pediatrician, a Providence dentist; and Dr. John Farrell, Executive Secretary of the Rhode Island Medical Society. From the meeting in November of this committee suggestions were made for more emphasis on an early spring Health Day program in the schools for new mothers to inform them of the need of early pre-school examinations and to prepare the mothers for the adjustments, both mental and physical, which the children will have to make their first year in school."

The Committee of the Association serves mainly as an advisory group on the medical procedures involved in the pre-school round-up. During 1947 it was not necessary to hold any meetings.

Respectfully submitted:

CHARLES B. LEWIS, M.D., *Chairman*
ROBERT M. LORD, M.D.
MERLE M. POTTER, M.D.
MICHAEL J. NESTOR, M.D.
TEMPLE BURLING, M.D.
JOHN T. MONAHAN, M.D.

READING ROOM

Evening Hours: (January 2, 1947 through December 11, 1947)

The Library was open 102 evenings. The total number of visitors was 262. Of these, 98 were physicians. The remaining 164 included students, teachers, nurses, dentists, etc. Evening hours seem to be growing in popularity.

Binding:

One hundred and forty volumes have been bound this year; 1 repaired. Six volumes are at the bindery now.

Journals:

The Association paid for subscriptions to 36 medical journals during 1947 - over half of the most widely read specialty journals.

The JOURNAL OF BONE & JOINT SURGERY, for which the Providence Medical Association pays, will be published in two volumes in 1948, one American, one British—thus doubling the number of issues of this important journal.



The Alkalol Company, Taunton 12, Mass.

The first Reading Room Committee of the Providence Medical Association was appointed in May, 1877. It started subscriptions to five British and six American journals. All the journals were presented to the Rhode Island Medical Society in 1880, and the Association has continued to subscribe for journals for the State Society ever since.

Respectfully submitted,

IRVING A. BECK, M.D., *Chairman*

COMMITTEE ON TUBERCULOSIS

Your committee has continued to work on the problems of tuberculosis control. A plan for tuberculosis control in the hospitals of Rhode Island was drawn up and sent to the various hospitals in the State. A copy of this was published in a previous issue of the JOURNAL. A follow-up letter is to be sent annually to these hospitals with a form to be filled out, indicating what procedures are used and what results are obtained.

Because of the shortage of tuberculosis beds and the consequent long waiting lists for patients seeking treatment for tuberculosis, a sub-committee was formed to study conditions at Wallum Lake Sanatorium. It was the hope that they might be able to find some means by which more patients could be handled. After their visit to the Sanatorium, it was felt that everything within reason was being done, that the shortage of beds was a result of difficulty in hiring and keeping personnel at the Sanatorium. It appeared that the only means of immediate improvement would be to cut down the stay of the Sanatorium patients to the minimal period compatible with adequate care.

The Committee is of the opinion that to further promote interest and understanding of tuberculosis problems, it would be advisable for the various county medical societies to appoint tuberculosis committees for the purpose of studying and handling local problems.

The matter of tuberculosis control amongst school teachers has been discussed, and the Committee is of the opinion that it would be advisable to have chest plates of all teachers annually. Further, it would seem advisable to have annual x-rays of all schools employees, especially those who come in close contact with pupils. A definite program for this procedure has not yet been worked out.

The Eastern Section of the American Trudeau Society has been inactive during the War years. The Officers of the Section are interested in carrying out a program that will be helpful to the localities covered by this Section and have requested recommendations from the various states. In discussing this matter, the Committee felt that the Section would serve a more useful purpose if it were not so large, if there were a New England Section to represent this particular region, and that it might combine with other local groups interested in tuberculosis in order to prevent a certain amount of repetition and to provide a more unified program. It was suggested that the Eastern Section might draw up a list of speakers who could be called upon to give talks to local societies on various aspects of tuberculosis. These recommendations will be presented at the forthcoming meeting of the Eastern Section of the American Trudeau Society.

JOHN C. HAM, M.D., *Chairman*
U. E. ZAMBARANO, M.D.
PHILIP BATCHELDER, M.D.
JOHN PINCKNEY, M.D.
PETER F. HARRINGTON, M.D.
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CARL D. SAWYER, M.D.
Practice limited to Dermatology and Syphilology
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184 Waterman Street Providence, R. I.

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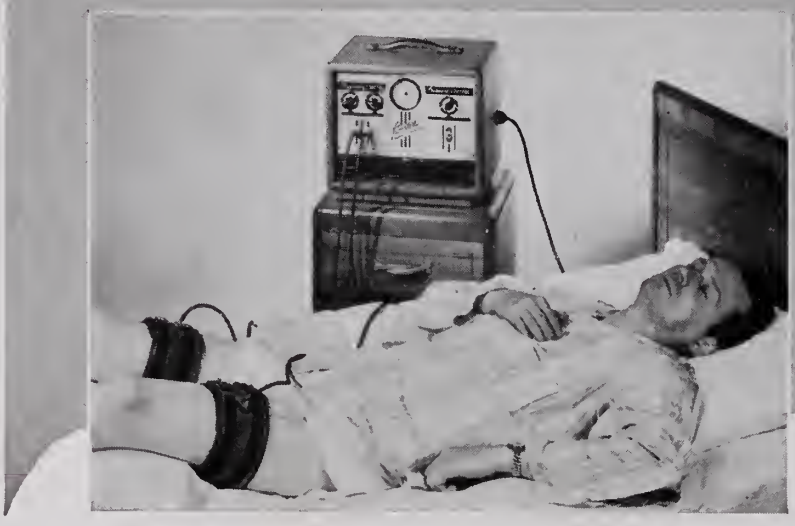
THE RHODE ISLAND MEDICAL SOCIETY

THE RHODE ISLAND MEDICAL SOCIETY • HOSPITAL ASSOCIATION OF RHODE ISLAND

Volume XXXI, No. 3

Contents Page 159

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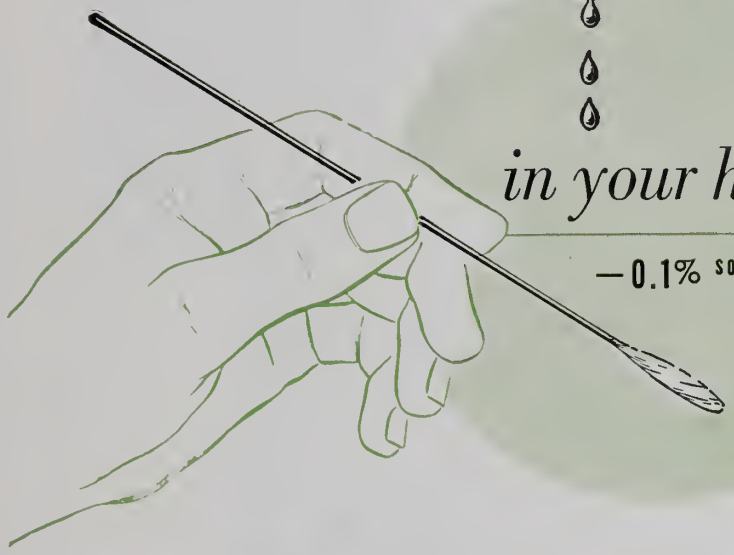
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TABLE OF CONTENTS

PAGE

The Position of the General Practitioner Today, *James M. Faulkner,* M.D. 167
Leaves Off the Tree (Centennial Oration), *Reginald Fitz,* M.D. 171
Graduate Medical Education and Hospital Economics, *Oliver G. Pratt* 177
Admission to Medical Schools, *Dwight O'Hara,* M.D. 186
Intern Training in the Hospital System, *Charles F. Wilkinson, Jr.,* M.D. 201

EDITORIALS

The Rhode Island College of Pharmacy 183
Woman Physicians 183
Centennial 184
Truth and Circumstances 184
Kent County Hospital 185

DEPARTMENTS

Book Reviews 212
District Society Meetings 192
Interim Session of A M A House of Delegates, Report of Delegate 208
Providence Medical Association, Roster of Committees, 1948 220

MISCELLANEOUS

Index of Advertisers 219

Photographs:

Jeannette E. Vidal, M.D., President, Kent County Society 192
Philomen P. Ciarla, M.D., President, Newport County Society 195
Scenes from Providence Medical Association Centennial Dinner 176



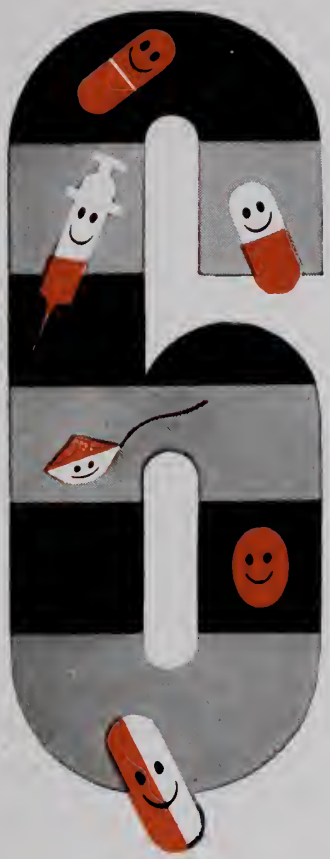
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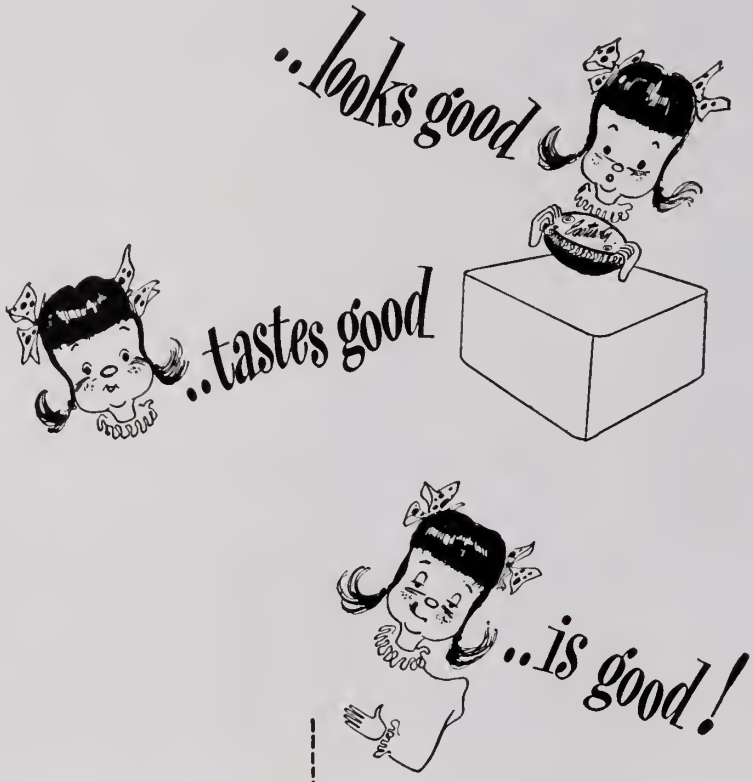
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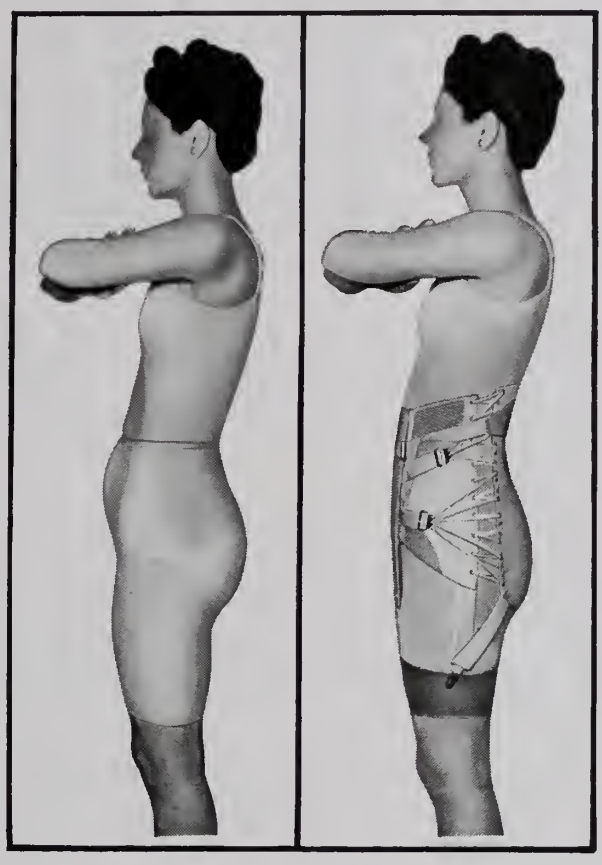
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*The Uses of Vitamins in the Treatment of Chronic Arthritis; Traeger, C.H.; The Medical Clinics of N. Am. 30:616 (May) 1946.

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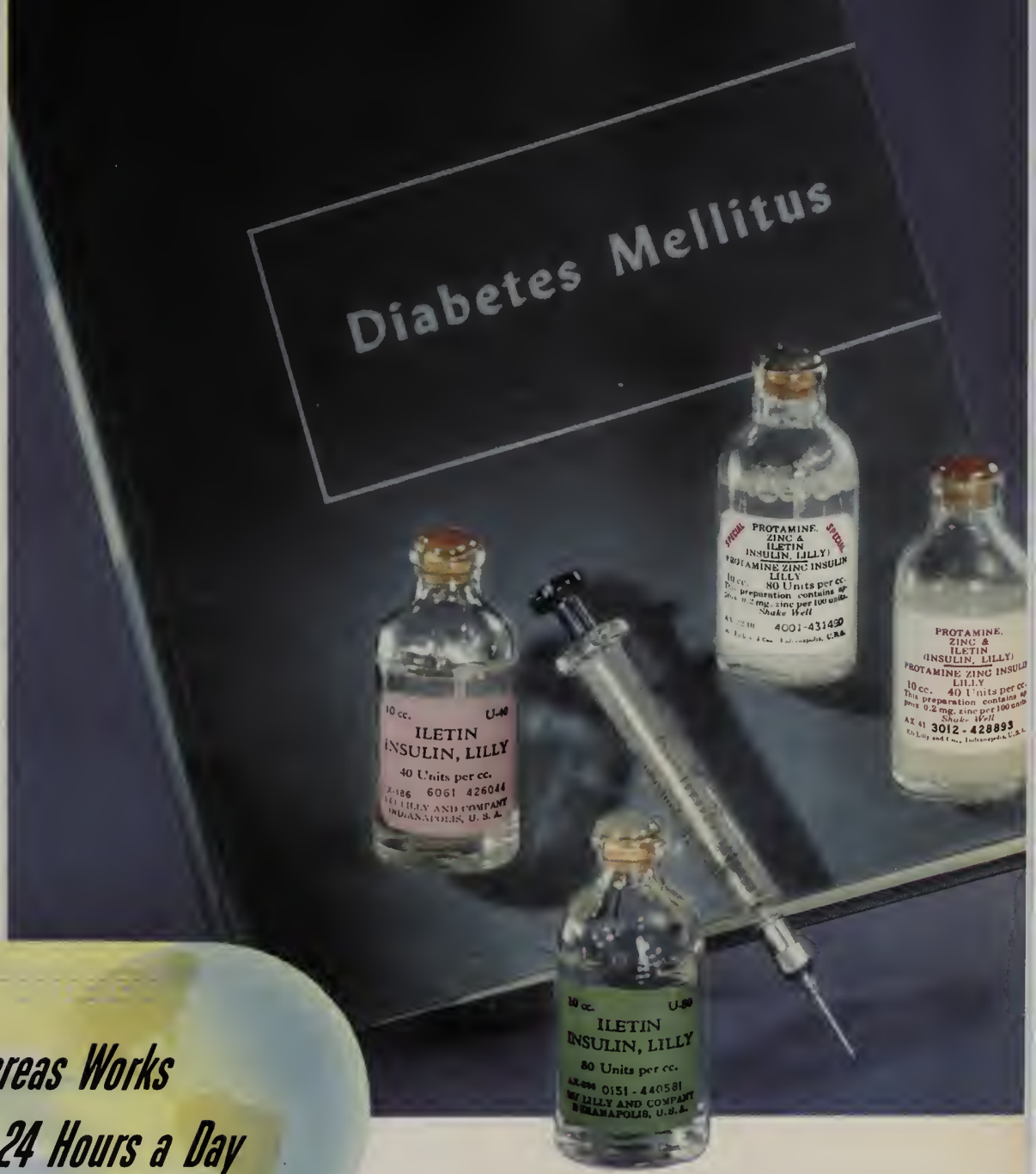
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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXI MARCH, 1948 NO. 3

THE POSITION OF THE GENERAL PRACTITIONER TODAY

JAMES M. FAULKNER, M.D.

The Author. *James M. Faulkner,* M.D., *of Boston. Dean, and Professor of Clinical Medicine, Boston University Medical School.*

WHEN I WAS INVITED to talk to you on this topic tonight I accepted gladly, although fully realizing that I was rushing in where angels fear to tread. It is indeed a subject on which strong opinions are voiced and yet no one can speak with authority. It is perhaps the most pressing problem which faces the medical profession today, and its solution will require all the tact and resourcefulness and submergence of selfish interest which we can bring to bear on it. We cannot afford to evade the issue. To do so would be running the risk of allowing the situation to degenerate into futile jurisdictional strife. It is to be hoped that objective and open-minded discussions such as we are having here tonight may help to clarify the present status of the general practitioner and to point out what can be done to give him a more assured status in the medical economy of the future.

In approaching this subject, I wish to make it clear that I am not going to touch on the subject of rural medicine which is a separate and distinct problem.

In order that you may make due allowance for my own prejudices, I should confess to you at the outset that I have been a specialist in internal medicine ever since I went into practice some twenty years ago and that for the last six months I have given full time to problems of administration and education in a medical school. However, as the son of a general practitioner of the old school who used to take me along on many of his calls in buggy or sleigh, I did get some appreciation of the role of the family doctor in a small town and the respect which he enjoyed not only in the community but also among his professional colleagues.

The status of the general practitioner has changed considerably since those pre-World War I days. The rise of the Specialty Boards to positions of great power and influence has stimulated tremendous interest on the part of young men preparing for practice but at the same time it has produced a feeling of uneasiness in the general practitioner, who up to recently has had no organized group of his own through which to make his voice heard. He has seen appointments to hospital staffs made dependent on board certification. He has seen rank and pay made dependent on board certification in the armed services and in the Veterans Administration. He sees fewer and fewer men going into general practice. He feels that the prestige of the family doctor is slipping and he becomes dispirited if not disgruntled.

If we examine the factors responsible for the change in status of the general practitioner we shall see that they fall naturally into two classes: (1) socio-economic factors common to the whole community, and (2) changing standards of practice set up within the medical profession itself. Let us look at the socio-economic factors which have influenced the practice of medicine.

Improvement in transportation and communication. Without question, the automobile and the improved roads have tremendously widened the area which a practitioner can serve, and at the same time the telephone has made him more accessible. The effect has also been to give patients

continued on next page

* Presented at the joint meeting of the Rhode Island Medical Society and the Providence Medical Association, at Providence, February 2, 1948.

access to more doctors, including specialists, and to more hospitals.

The urbanization of our country to the point where now 60% of the population live in cities, instead of 30% a generation ago, has simply intensified all of the factors above mentioned.

A general increase in the standard of living has made it possible for a larger proportion of the population than formerly to pay specialists fees and hospital expenses, and this shift has been to some extent at the expense of the general practitioner.

Along with urbanization, a higher standard of living and *wider dissemination of health information,* there has been a marked trend toward *more hospitalization.* A conspicuous example of this is in Obstetrics, which has always been one of the main supports if not the backbone of general practice. The hospitalization of obstetrical cases has reached the point in Massachusetts where many large towns do not register a single home delivery in the course of a year and, in Boston at least, the district deliveries by medical students are a thing of the past.

The tendency to increased hospitalization applies to other fields besides Obstetrics and unquestionably this tendency has been further increased by the Blue Cross. The desirability or undesirability of increased hospitalization we are not concerned with now. I simply wish to make the point that in recent years a larger segment of practice has been carried on in the hospital rather than in the home. The importance of this is that hospital practice is more or less regulated, whereas house practice is not. In the hospital the doctor must submit to the rules laid down by the Trustees and Staff, rules which restrict the procedures which members of the staff are permitted to carry out and which regulate new appointments and promotions. In a number of hospitals, specialty board membership has been made a prerequisite for membership on the staff, for certain positions on the staff or for sanction to perform certain operations. This practice has sometimes worked an unfair hardship on well qualified men who had not taken their boards. It has become the subject of bitter criticism and has been officially disapproved by the Advisory Council of Medical Specialties as well as by a number of the constituent specialty boards. As it has worked out, the number of instances where a qualified general practitioner has actually lost his staff membership because of lack of Board certification is probably not large. In many more instances, general practitioners have been told that they could no longer undertake major surgical operations or major obstetrical procedures because they did not possess the proper Board qualifications. In larger hospitals, however, there has been a tendency to restrict new appointments to the staff to Board men. The general shortage of hospital beds and the argument that such a policy automatically protected high standards of practice within the hospital made such regulations attractive alike to Trustees and staff. The effect in those communities has been to deny to young general practitioners who have not yet established their hospital connections any opportunity of doing so. Incidentally, a good many of the harsh words which have been said about the Specialty Boards in this controversy might better have been directed against the hospital authorities. Too often the hospital has used the Boards' requirements as a convenient and outwardly impersonal way of disqualifying men for staff membership or promotion rather than attempting its own evaluation of his qualifications—admittedly a very different job, especially in a small hospital. Without delving into this aspect of the problem any deeper, I think we will agree that on the whole general practitioners have yielded ground to specialists in hospital practice.

So much for the factors which have put the general practitioner where he is today. What is his outlook for the future? Is he going out of existence like the horse and buggy? It seems safe to predict that as long as our system of private medical care exists the family physician will continue to carry the bulk of the practice. Indeed, outside of a completely regimented medical economy with no individual choice of a physician, it is impossible to conceive of medical care without the family physician. Even were we able to eliminate completely that aura of sentiment and affection which is attached to the name of family physician, we would still find that from the purely practical point of view he plays an absolutely essential role in the profession; for he with his intimate knowledge of the family background is in a unique position to evaluate the patient's symptoms in their true perspective. He, better than the specialist, can understand the patient as a social human being rather than as an assortment of organs. Even if, as seems possible, more and more practice is going to be done in groups, there is no reason why the general practitioner might not hold the key position in such groups. All new patients would pass through his hands and would be referred to specialists only if he deemed it necessary. He would be the logical member of such a group to maintain the old doctor-family relationship. Whatever further evolution may take place in the content of general practice there will always be a demand and a need for the family physician. If we accept this statement as true, then the question arises as to whether we should take a positive attitude toward

the problem or whether we should adopt a laissez-faire attitude.

The problem is too immediate and too complex for sidestepping the issue. Affecting as it does the very bone and sinew of the profession, it cannot be allowed to fester.

What is being done to correct the situation? A good deal is being done from many different angles. I shall discuss three different approaches to the problem: (1) the medical schools, (2) the hospitals, and (3) organized medicine.

I have occasionally heard people deplore the fact that medical schools turn out so many specialists, as if a medical school *could* turn out a specialist and as if medical schools had any control over what types of practice its graduates took up. It is true that practically all teaching in medical schools is done by specialists, and it may well be that this exerts an influence on students to become specialists themselves. It is not an easy matter to counteract this influence by bringing medical students in significant numbers into intimate contact with first class general practitioners. The University of Vermont Medical School has done this by assigning fourth year students as clinical clerks in rural hospitals throughout the state under the guidance of certain local practitioners who hold official teaching positions in the School. These students have an unusually good opportunity to observe general practice at first hand, and many of them choose that field on graduation. A number of medical schools, including Tufts and Boston University, have a course in so-called District Medicine in which the students make house calls and get at least a smattering of an idea of the problems of caring for a patient in the home. However, training for general practice must necessarily be largely a post-graduate affair.

The medical schools could further the training of general practitioners by assisting hospitals to develop intern and resident programs specifically oriented toward general practice. The University of Colorado has recently organized such a program with the help of the Kellogg Foundation. The Tufts College Medical School, The University of Rochester Medical School, and others are actively engaged in trying to build up good post-graduate training programs in smaller hospitals for the benefit of future general practitioners. Much remains to be done along this line in New England. There is too much of a gap between the first class rotating internship, such as is offered by the Rhode Island and the Hartford Hospitals, and the second class internships. Too many first class hospitals have second class internships and as a result are having difficulty filling their quota of interns. In my opinion, and I am sure that my opinion is shared by most students who are seeking internships, the one year rotating iternship is inadequate preparation for general practice. Every hospital which is large enough to provide adequate teaching material should establish two year internships. The first year could be on a rotating basis and the second year could be devoted largely or exclusively to medicine or surgery and of such a calibre that it would receive Board approval as an assistant residency if the incumbent wished to proceed along the road to Board certification in Internal Medicine or in Surgery. The important point is that when the man is accepted as an intern it would be understood that he would be kept on for a second year if his services were satisfactory. This second year of training would go far in eliminating the too great discrepancy which now exists between the training of the general practitioner and the specialist and would, in my opinion, add greatly to the stature of the young general practitioner. Of course, an internship as such has very limited value unless it is conducted as a well organized, well integrated teaching program preferably under the direction of one member of the staff who is charged with this responsibility. In the course of many interviews with students seeking advice on internships I have found that they are apt to judge a hospital more on the basis of its teaching program than on any other factor. Competition for interns will, I believe, force hospitals to develop more adequate teaching programs than they have in the past. In a larger measure than ever before, the training of our future general practitioners is becoming a hospital responsibility. The medical schools might logically be asked to assist in the development of such programs but they are not in a position to initiate them.

On the burning issue of staff appointments, some hospitals have rescinded previous rules requiring Board certification. An important new development has been the establishment of general practice divisions in the staffs of a number of large hospitals. The general practice service, like the surgical service or the medical service, has its own chief and holds its own Staff meetings. This arrangement gives the general practitioner the opportunity to care for his patients in a hospital within the limits of his qualifications together with all the educational advantages and prestige factors which go with a hospital staff appointment.

In June, 1945, the American Medical Association gave recognition to the special problem of the general practitioner by organizing the Section on General Practice. Some physicians have thought that this was not going far enough. Repeatedly over the years resolutions have been introduced into the House of Delegates calling for the creation of a specialty board in general practice. This idea

continued on next page

has not met with general favor. If such a board were to have any meaning at all, it would have to set high standards. High standards in such a broad field as general practice might indeed be harder to meet than the existing standards of some of the specialty boards. The chances are that only a small fraction, perhaps 10%, of the general practitioners would have the time, energy, and ability to meet the requirements. This would leave the vast majority of the general practitioners in a far unhappier position than they are in now.

In June, 1947, the American Academy of General Practice was organized at Atlantic City. Its official objectives are as follows:—

"Objectives:—

(1) To promote and maintain high standards of the general practice of medicine and surgery.

(2) To encourage and assist in providing post-graduate study for general practitioners in medicine and surgery and to encourage and assist practicing physicians and surgeons to participate in such training.

(3) To encourage and assist young men and women to prepare, qualify, and establish themselves in general practice.

(4) To protect the right of the general practitioner to engage in medical or surgical procedures for which he is qualified by training or experience.

(5) To advance medical science and private and public health.

To be eligible for membership the physician must be engaged in General Practice. He must be duly licensed in the state in which he practices, and must be of high moral and professional character. He must have had at least one year of rotating internship at an approved hospital, or the equivalent in post-graduate training. He must have been in General Practice for at least three years. He must have shown interest in continuing his medical advancement by engaging in Post-Graduate educational activities."

To continue as a member it is necessary to complete 150 hours of Post-Graduate work in each three year period. In fulfilling these requirements, it is expected one-third of this time may be spent at staff meetings, one-third at conventions, and one-third at Post-Graduate courses. The emphasis on continued post-graduate education is laudable and it looks now as if the general practitioner were going to have a strong national organization to look out for his interests.

The kinship between the general practitioner and the internist is a very close one. Their field is very much the same. It is usually one or the other of these two who sees the patient first and who has the responsibility for making the preliminary diagnoses. If one projects present trends into the future, one would predict that in another generation the family doctor will be doing little or no obstetrics and no major surgery but will be confining his attention almost entirely to internal medicine and pediatrics. This close affinity has been recognized by the American Board of Internal Medicine which has liberalized the requirements for certification for that Board by allowing credit for years spent in practice to be substituted for residency requirements in qualifying for the examination. Four years of practice in internal medicine are given credit equivalent to one year's residency in internal medicine. The basic requirements for the American Board included one year of internship, three years of residency or fellowship in internal medicine, and two years of practice. Under the new provisions, a man may take only one year's residency and substitute eight years of practice for the remaining two years of residency requirement, or he may after twelve years' practice of internal medicine qualify for the Board examination without any more formal post-graduate training than an approved internship. This means that a man who for personal or economic reasons may not be able to spend three years in residency training still has an opportunity to obtain Board certification later on if he can pass the examination.

In closing, may I summarize my remarks in a few words.

(1) The relative position of the general practitioner as a group within the medical profession has suffered as a result of several factors, chief among which are: (a) socio-economic factors which are to a large extent beyond our control; (b) changing standards of medical practice which have worked to the advantage of the specialists; and (c) the rise of the specialty boards with their well organized and vocal national groups to which the general practitioners have had no counterpart.

(2) Efforts are being made to restore a proper balance between the general practitioner and the specialist by: (a) The development of internship and residency programs specifically organized to train men for general practice. (b) The establishment of a Section on General Practice in the American Medical Association. (c) The liberalization of the requirements for certification by the American Board of Internal Medicine which permits a practitioner to substitute a certain number of years of practice in internal medicine for the hitherto rigid residency requirements. (d) The formal disapproval by the specialty Boards of board certification as a requirement for hospital staff appointments. (e) The establishment of general practice sections in hospitals. (f) The organization of the American Academy of General Practice.

continued on page 182

LEAVES OFF THE TREE*

REGINALD FITZ, M.D.

The Author. *Reginald Fitz, M.D., of Boston, Mass. Member, Council on Medical Education and Hospitals, American Medical Association; Past President, Massachusetts Medical Society; Lecturer, History of Medicine, Harvard Medical School; Charles V. Chapin Orator, 1944.*

THE AUTOCRAT, as everyone knows, was a very wise old gentleman. He made a profound observation at the breakfast table one morning when he said that in New England we are apt to go for the man — and he might have added, for the Medical Society — that inherits family traditions and the cumulative humanities of at least four or five generations and that has a gallery of family portraits to be proud of.

Today, the Providence Medical Association has passed the century mark. It has managed to grow younger and more vigorous year by year so that it must have discovered the secret of perpetual youth. How has it survived so gaily more than a thousand and one nights of strenuous programs?

Sixteen years ago, in his President's Address, Dr. John E. Donley was the most recent member, until he and Dr. Chase and Dr. Hammond re-told it, to tell the story of the Association's early days: how on January 31st, 1848, at the office of Dr. H. W. Rivers, the Association was born; how Dr. S. Augustus Arnold was elected the first President, Dr. J. W. C. Ely the first Secretary, Dr. Lewis W. Clifford the first Treasurer; and how its first Standing Committee included, among others, Dr. Henry P. Pratt.

I mention the names of Clifford, Ely, and Pratt with especial pride because they were graduates of the Harvard Medical School and therefore, by adoption, if you like, Proper Bostonians. They proved an interesting triumvirate. Clifford was the senior member, an older man recommended for admission to the School by no less a personage than Dr. Usher Parsons. He was thirty-nine years old when he received his medical degree in 1845; perhaps his age and his general gravity of deportment made him appear the most suitable candidate to become the original custodian of the Association's purse. Not much is known of him, unfortunately, beyond that he served honorably and that no eyebrows were raised over his accounting system.

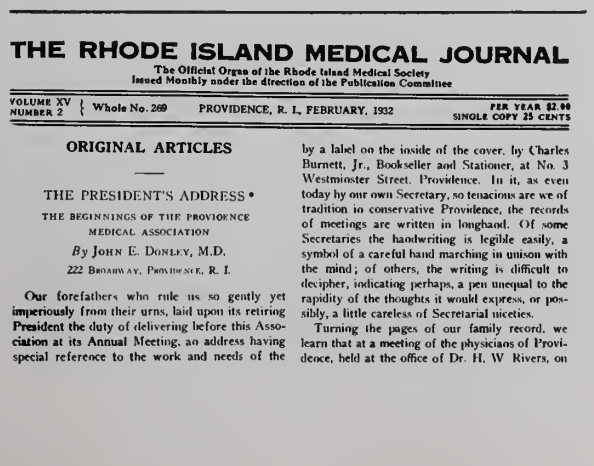
Dr. Ely and Dr. Pratt as students were more typical of the ordinary undergraduate of today; mannerly boys who were popular among their fellows and soon able to attract the favorable attention of their professors. Dr. Ely graduated in 1846 and Dr. Pratt in 1847.

While they lived in Boston these three Rhode Islanders, I presume, occupied lodgings close to-

continued on next page

* Presented before the Providence Medical Association at its Centennial Celebration, at Providence, January 31, 1948.

Title pages of the first two published histories of the Association. The Atlantic Medical Weekly went out of existence in 1899. The RHODE ISLAND MEDICAL JOURNAL began in 1917.



THE RHODE ISLAND MEDICAL JOURNAL

The Official Organ of the Rhode Island Medical Society
Issued Monthly under the direction of the Publication Committee

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ORIGINAL ARTICLES

THE PRESIDENT'S ADDRESS *

THE BEGINNINGS OF THE PROVIDENCE MEDICAL ASSOCIATION

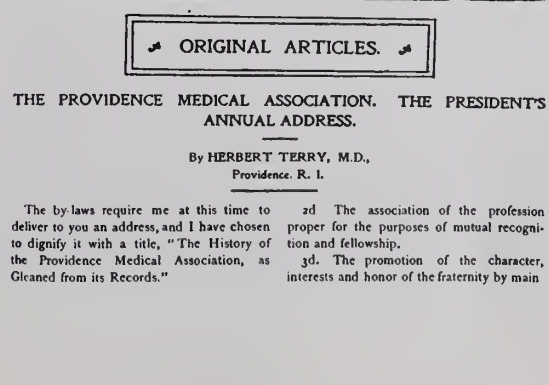
By JOHN E. DONLEY, M.D.

222 BROADWAY, PROVIDENCE, R. I.

Our forefathers who rule us so gently yet imperiously from their urns, laid upon its retiring President the duty of delivering before this Association at its Annual Meeting, an address having special reference to the work and needs of the

by a label on the inside of the cover, by Charles Burnett, Jr., Bookseller and Stationer, at No. 3 Westminster Street, Providence. In it, as even today by our own Secretary, so tenacious are we of tradition in conservative Providence, the records of meetings are written in longhand. Of some Secretaries the handwriting is legible easily, a symbol of a careful hand marching in unison with the mind; of others, the writing is difficult to decipher, indicating perhaps, a pen unequal to the rapidity of the thoughts it would express, or possibly, a little careless of Secretarial niceties.

Turning the pages of our family record, we learn that at a meeting of the physicians of Providence, held at the office of Dr. H. W Rivers, on



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ORIGINAL ARTICLES.

THE PROVIDENCE MEDICAL ASSOCIATION. THE PRESIDENT'S ANNUAL ADDRESS.

By HERBERT TERRY, M.D., Providence, R. I.

The by-laws require me at this time to deliver to you an address, and I have chosen to dignify it with a title, "The History of the Providence Medical Association, as Gleaned from its Records."

2d The association of the profession proper for the purposes of mutual recognition and fellowship.

3d. The promotion of the character, interests and honor of the fraternity by main

gether on Beacon Hill so that in winter they could slide down comfortably to their clinics at the Massachusetts General Hospital and there become exposed to the wisdom of such teachers as Dr. John C. Warren in Surgery, Dr. Walter Channing in Obstetrics, and the notorious Dr. Webster in Chemistry. And Pratt had additional initiative — or money — with which to enroll for a spring term in the newfangled Tremont Street Medical School and to encounter the more modern and radical teachings of Dr. Oliver Wendell Holmes, Dr. Humphreys Storer, and young Dr. Henry J. Bigelow.

The course at Harvard consisted almost entirely in lectures with the single mitigating circumstance that in Medicine the students actually handled patients and, according to the Catalogue, thus were given opportunity of learning the new method of "exploration of the body for the PHYSICAL SIGNS of disease by *palpation*, *auscultation* and *percussion*". Otherwise they spent their time as listeners, absorbing through their ears, as best they could, the whole Science of Medicine.

At the Tremont Street School, on the other hand, the course was livelier and less theoretical. Dr. Storer supervised young Pratt in delivering a number of babies on the District, Dr. Holmes introduced him to the mysteries of the microscope, and Dr. Bigelow made him feel at home at the bedside on surgical ward rounds at the Hospital.

Medical student life, as it always is, was fairly strenuous; almost the only social outlet, except for an occasional toddy, was to be found in meetings of the Boylston Medical Society. The story goes that a worthy gentleman by the name of Ward Nicholas Boylston inherited a considerable fortune from an uncle who had been successful in the China trade and a fair share of this he finally bequeathed to Harvard College. One of his forbears was Zabdiel Boylston, the inoculator, and from him Ward Nicholas claimed an inherited interest in medicine.

The Boylston Medical Society, named in honor of Mr. Boylston, was more than thirty years old and a thriving affair when Clifford, Ely, and Pratt came along; both Clifford and Pratt became members.

At each meeting an original paper was presented; there was general discussion; and finally, there were reports of cases or reports on other matters connected with Medical Science. It was a juvenile performance but a form of initiation into medical society procedure and, moreover, the meetings were pleasant, occasionally developing arguments which proved both heated and entertaining. At one meeting, for instance, the paper to be heard was entitled, "Does the moderate use of Tobacco in its various forms tend to injure the health of the system?"

One must remember that the Quaker influence of Rhode Island was still perceptible in Boston and that many parents liked to quote to their sons, when they seemed to be smoking too much, a paragraph from Dr. Benjamin Waterhouse's well known lecture on The Evils of Tobacco:

> The practice of smoking is productive of indolence, and tends to confirm the lazy in their laziness. Instead of exercising in the open air, as formerly, you sit down before large fires and smoke tobacco. This hot fumigation opens the pores of the head, throat, neck, and chest; and you pass out in a reeking sweat into a damp, cold atmosphere; the patulent pores are suddenly closed; hence arise disorders of the head, throat, and lungs. These causes, cooperating with those already mentioned, produce those hectical symptoms and consumptive complaints, that have been multiplying among you to an alarming degree; for this nasty custom includes the destructive effects of indolence, and the pernicious effect of the too frequent use of vinous and ardent spirits; agents, destructive to full grown men; but which act with redoubled force on the more susceptible frames of young gentlemen in the spring of life.

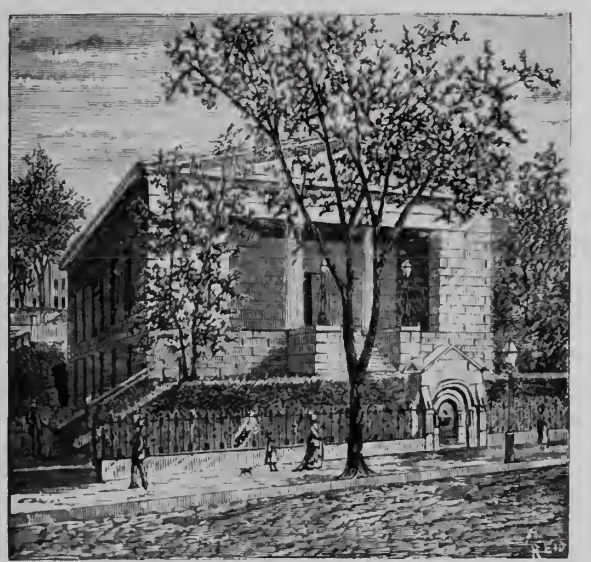
Dr. Waterhouse must have turned in his grave that night as the members of the Boylston Medical Society voted vociferously in favor of the harmlessness of the weed that he so earnestly claimed was an invention of the Devil. No doubt he would have regarded the conduct of the Boylston Medical Society as a further manifestation of Harvard decadence.

There were two more mature medical societies that had considerable influence at the time: the Boston Medical Association and the Boston Society for Medical Improvement. The former did little else than act as Medical Police, establishing a Code of Ethics and a Fee Table. The latter was more active, founded to "cultivate the confidence and good feeling between members of the profession, and to elicit and impart information upon the different branches of medical science". This was the organization before which members of the Harvard and Tremont faculties read their most important papers.

While neither Dr. Clifford, Dr. Ely nor Dr. Pratt belonged to the Boston Medical Association nor to the Society for Medical Improvement, yet probably they knew of their existence and something of their organization. At least it seems a curious coincidence that the Providence Medical Association, with these three Bostonians among the Founders, first assumed Police Powers and established a Fee Table very similar to that of the Boston Association; and that presently when, as Dr. Donley said, the Providence group turned its attention to matters medical, a type of program was adopted that was closely parallel to the one used by the Boston Society for Medical Improvement. From this evidence, tenuous as it is, it is possible, as I like to believe, that these three prod-

ucts of Harvard added an enduring tinge of Crimson to the Association's background colored otherwise so deeply Brown; this, perhaps, may be one reason why Bostonians feel at home at meetings of the Providence Medical Association and have always regarded an invitation to attend any of them as a particularly delicate compliment.

The Association soon established the tradition of progressiveness. After having determined to meet in the Franklin Society's rooms, one of the obvious needs was that of keeping abreast of the times through means other than conversation. Thus, at the December meeting in 1848, Dr. C. W. Parsons suggested that a medical library be formed by subscription, the books and periodicals so accumulated being deposited in the Athenaeum or some other suitable place. The Rhode Island Medical Library grew from this beginning.



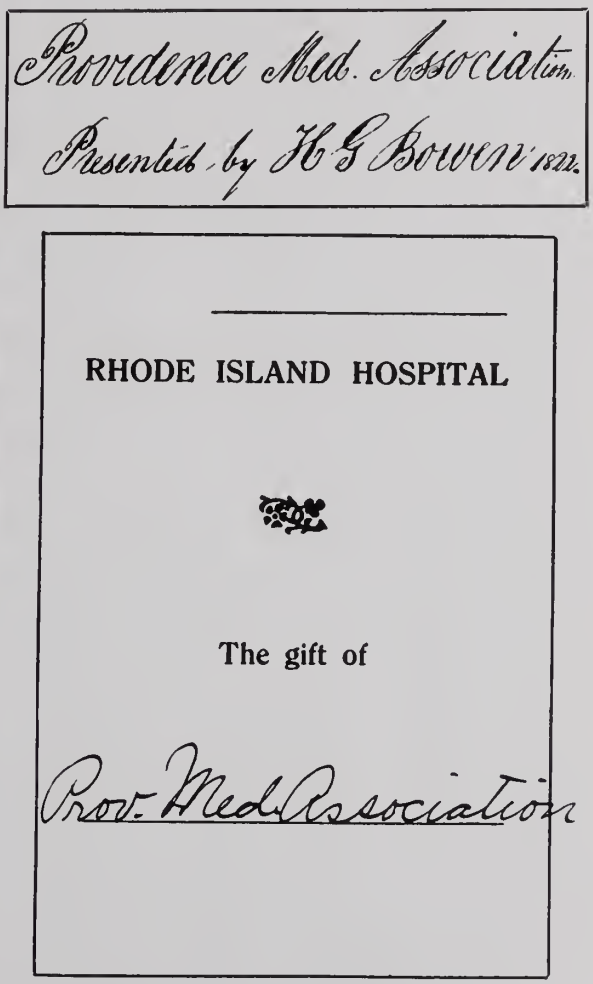
The Athenaeum. During 1848 the Association met in the rooms of the Franklin Society in the basement of this building and later in their rooms on North Main Street. In 1905, because it needed more space, the Association moved to Rhode Island Hall at Brown University and in 1912 to the Rhode Island Medical Society Library.

Periodicals were subscribed to and a few books were purchased until in 1868 the collection occupied so much space that it was transferred to the Rhode Island Hospital for safe keeping and a new and more active library of current literature was again started. This likewise grew rapidly so that in 1876 preliminary conferences were held to establish an adequate medical library for the use of all the doctors of Rhode Island, and in 1880 the second collection of the Providence Association was turned over to the Rhode Island Medical Society.

This collection, like its predecessors, grew rapidly and within ten years the matter of its housing once again presented serious difficulties; the upshot was that funds were gradually obtained for a permanent home and in October, 1912, the present library building was opened.

In the field of medicine the tradition of progressiveness was equally notable. Every useful discovery as it came along was discussed: in the early days, obstetrical problems and those arising from the infectious diseases that visited Providence received most attention. Yet the advantages of ether as an anesthetic agent were described in 1848, and in 1857 a perforated appendix from a fatal case of appendicitis was exhibited. When the time came to establish hospitals and a Board of Health, a purer water supply and better roads, the Association took the lead in their development. As medical novelties cropped up they received the Association's attention: oleomargarine as a substitute for butter in 1876; the telephone in 1883;

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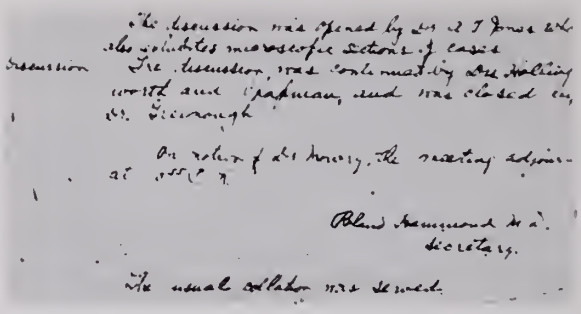


Two early book-plates used for marking the Association's books. Mr. H. G. Bowen was Professor of Natural History in Brown University from 1824-1828 and Librarian from 1828-1840. The exact significance of the figure "1822" is uncertain. From 1868 until 1880 the library was housed in the Rhode Island Hospital. The book-plates are reproduced by courtesy of Dr. Philip Batchelder.

asepsis and the importance of bacteriology in 1891; the x-ray in 1896; tuberculosis control in 1900; the therapeutic use of radium in 1921; and so on down to today through electrocardiography, insulin, liver extract, the sulpha drugs and penicillin, and even to the development of insurance plans against the cost of medical care. Indeed, the minutes of the Association give a graphic account of medical progress during the space of a century, each new diagnostic or therapeutic weapon being described carefully and its advantages or faults being debated fairly and honestly.

A spirit of good fellowship and friendliness among members was another tradition to be cherished from the very beginning. When the Association was small, the President was in the habit of giving an Annual Dinner but this custom passed into desuetude seventy years ago when the task of entertaining more or less of eighty dry and hungry gentlemen seemed too heavy for any one person to bear. In 1879, a resolution was adopted by which a committee was appointed to determine the feasibility of introducing a social element into the Association and the result was the provision of a collation at each meeting forever afterwards, the funds for its cost being drawn from the Treasury. Many Presidents have commented on the wisdom of this procedure; food after a medical meeting undoubtedly promotes friendliness and tends to soothe ruffled feelings.

As the Association became securely established, means for maintaining a printed record of its proceedings were developed. At first, notices of meetings and accounts of what happened at them from time to time appeared in the Providence Journal. After nearly thirty years the Association voted that henceforward no such publicity was proper, and the next vehicle of publication was a periodical known as the Rhode Island Science Monthly which soon turned into the Atlantic Medical Weekly. Neither of these journals proved an entirely satisfactory means of reporting the affairs of the Association though scattered through them can be found a good many of the Association's papers. In 1899, the Providence Medical Journal came into existence, published quarterly by the Association and reporting regularly not only the minutes of the meetings but also many of the papers which were delivered. In 1916, it fell into financial difficulties and sold its rights to the Rhode Island Medical Society. The Rhode Island Medical Journal which has been published each month since January, 1917, is thus the child of the Association and has grown into a very satisfactory adult under its parent's care. It continues to print the minutes of the meetings and a fair share of the original contributions. A microfilm of the early records of the Association is now available so that at last the history of the Association is well documented in several ways and in accessible form.



A bit of the microfilm. The film makes the Association's early records readily available.

The two pillars of progressiveness and friendliness make a sound foundation on which to build success in any medical society. Yet without vigorous and colorful personalities by which to make the superstructure warm-hearted and enduring, the potential value of such a foundation would be wasted. The essential humanities of the Association which have accomplished this are difficult to describe. They are complex, wholly charming, and distinctive. Perhaps the best way to appreciate them is to turn the clock back and attend a few of the earlier meetings in order to see for oneself how they set the pace for the future.

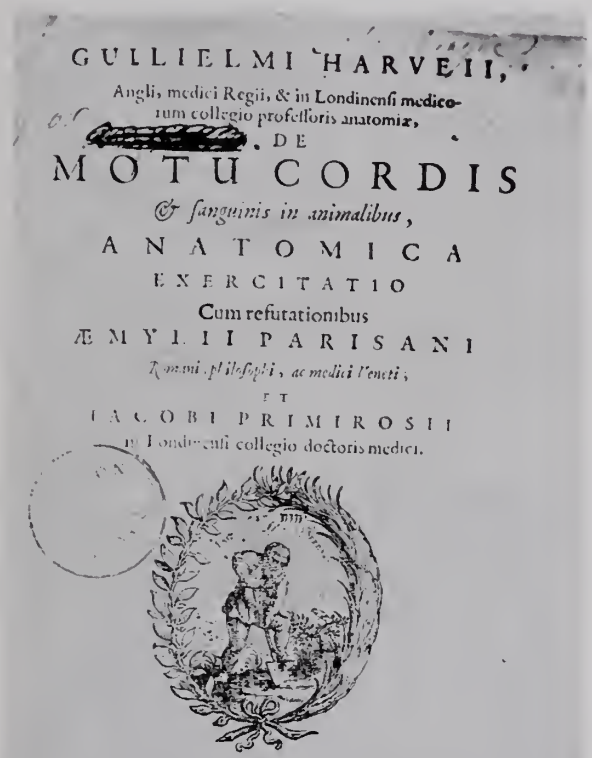


The Squantum Club. "Composed of Rhode Island gentlemen, it is an association for culture and recreation. It owns a club house at Squantum, a rocky promontory about opposite Field's Point". It originated in 1870 with a number of Rhode Islanders who enjoyed an old-fashioned clambake. The Association dined here on Tuesday, July 14, 1874. A generous Clam Bake and mill punch a-la-Gladding were among the delicacies served.

I wish that I could have gone to the meeting on July 14th, 1874, when Dr. C. T. Gardner arranged an invitation for the members to assemble at the Squantum Club House on the Narragansett Bay. At four o'clock in the afternoon the Association filled the dining room and a generous Rhode Island Clam Bake was presented, embellished, no doubt, with rum punch, speeches, toasts and stories, and lasting until late in the evening. That was one of those rare Rhode Island nights, I suspect, when,

as Dr. Holmes might have put it, the amiable indiscretions of nine months ago were largely overlooked. How the population of Providence became safely increased that evening remains a mystery.

I know that I should have enjoyed the September meeting in 1877 when Dr. George Brug displayed a copy of Harvey's description of the Circulation of the Blood, printed in Latin and published in 1639. I should like to have met him and seen his book and compared it with Dr. James Jackson's copy of a 1639 Leyden imprint and now living in the Harvard Medical School. Are the books identical twins? What are the stories connected with their purchase? What has happened to Dr. Brug's copy?


GVLIELMI HARVEII,
Angli, medici Regii, & in Londinensi medicorum collegio professoris anatomiæ,
DE
MOTV CORDIS
& sanguinis in animalibus,
ANATOMICA
EXERCITATIO
Cum refutationibus
ÆMYLII PARISANI
Romani philosophi, ac medici Veneti,
ET
IACOBI PRIMEROSII
in Londinensi collegio doctoris medici.
LVGDVNI BATAVORVM.
Ex officina IOANNIS MAIRE.
CIↃ IↃ C XXXIX.

Title page of Dr. James Jackson's copy of the 1639 imprint of Harvey's "De Motu Cordis". Dr. George Brug exhibited a copy of this book at a meeting of the Association in 1877. In 1913 only three copies were known to be listed in libraries of this country.

I wish I could have been present at the December meeting in 1886 when Dr. G. L. Collins persuaded the Anatomical Wonder to perform, a gentleman calling himself King George and claiming that he was three hundred and seventeen years old. He said that he had two hearts the sound of which could be heard either to the right or the left of the sternum and no diaphragm. As many of the members testified, he was able to stop the arterial circulation at will so that the action of the heart seemed under his immediate control and, also, he could change the shape of his abdomen so that he was able to develop peculiar tumor masses which were difficult to identify; in fact he tried to make people believe that he could move one of his hearts down into his groin. His strength was equally remarkable; he could bend and straighten an iron bar, one inch in diameter and long enough for a cane, by the simple expedient of striking it against his arm. From all accounts he was worth meeting.

Naturally, I should have gone to the June meeting fifty years ago when my old friend, young Halsey DeWolf, fresh from the Medical School of the University of Pennsylvania, was elected a member. He soon was appointed to serve on the Collation Committee, immediately, I expect, and for the endless benefit of posterity, improving the quality as well as the quantity of the food served. His first scientific contribution was in 1900 and on the subject of District Nursing. The children of Providence owe to him much of their good state of nutrition and their pure milk supply; his paper was the first to provoke local interest in two such important phases of public health work.

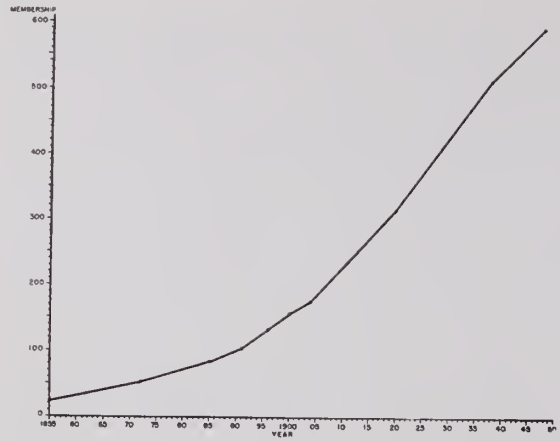
I should also have gone to the November meeting in 1900 when another of my friends and teachers — Dr. Frank T. Fulton — became a member. His maiden paper was not in the field of cardiology but in that of hematology. He spoke about the Anemias in Infancy and Childhood; his first paper dealing with Heart Disease came much later, at the December meeting in 1913, and on the use of Digitalis.

The custom of allowing occasional guests to appear on the program goes back eighty years when Dr. Lemercier of Paris told the Association about the development of the brain, illustrating his remarks with elastic models. Ever since, a number of visitors have been complimented by invitations to attend meetings. I wish I could have heard Dr. C. H. Mayo at the meeting held in his honor in April, 1915. He attracted a large audience, exceeded only by the one which subsequently gathered to hear Dr. Frank Lahey. Dr. Mayo and Dr. Lahey, between them, have the honorable distinction of being the two most popular speakers ever to appear before the Association during its First Hundred Years.

Dr. Mayo talked steadily for an hour. As usual, he was discursive but he emphasized his faith in Rosenow's work on focal infection; he said that no immunity to chronic disease was known, and finally he made the rash statement that stomach ulcer is never cured by medical treatment.

The steady growth of the Association is the last of its most striking characteristics. Not only has

continued on next page



The Association's growth in membership during its first hundred years.

the Association attracted many new and young members year by year who have regularly contributed papers and discussions but also has it passed along from one generation to the next, in the manner New Englanders are proud of, old names as well as old customs: a Parsons was followed by a Parsons, a Collins by a Collins, a Peckham by a Peckham; on the roster now, a Buffum follows a Buffum, a Burgess follows a Burgess, a Cutts follows a Cutts, a Fulton follows a Fulton, a Richardson follows a Richardson. And certainly no other medical society has ever had a Peter Pineo Chase, Secretary for fifteen years, President for one year, and at the moment capable Editor of the RHODE ISLAND MEDICAL JOURNAL in which the Association has such strongly vested interests.

The Providence Medical Association has every right, on its hundredth birthday, to be congratulated; not only on its accomplishments during the last century but also on its traditions, its cumulative humanities, and its family portraits. It can face the future with equanimity. Its character and its ideals will never change; it will go forward; it will always remain a unique Rhode Island organization, playing an important part in the medical progress of New England. After each meeting may the Secretary continue to add to the record with a flourish, after his description of the paper of the evening, the happy words: "The Association adjourned. The usual collation was served".



Dr. Philip Batchelder (right) receives from Dr. Arthur H. Ruggles, President of the Rhode Island Medical Society, the Distinguished Service Award of the Providence Medical Association on the occasion of the Association's Centennial Celebration, January 31, 1948.



A consultation as it might have appeared in 1848 is re-enacted at the Centennial celebration at the Providence Medical Association on January 31, 1948. Dr. G. Edward Crane, the patient, is viewed (left to right) by Dr. J. Merrill Gibson, Dr. Alex M. Burgess, Jr., Dr. John C. Ham, and Dr. Anthony Corvese.

GRADUATE MEDICAL EDUCATION AND HOSPITAL ECONOMICS*

OLIVER G. PRATT, FACHA

The Author. *Oliver G. Pratt,* FACHA, *of Providence. Executive Director, Rhode Island Hospital.*

I AM PLEASED indeed to discuss a subject that is a deep responsibility of every hospital administrator and is so close to the heart of each and every physician. By focusing our attention on this subject "Graduate Medical Education and Hospital Economics" and by discussion, we may clarify our minds and agree on a continuing working basis in the best interest of the people whom we are dedicated to serve.

This presentation will be limited in scope to the unique situation that prevails in Rhode Island — that is as applied to voluntary non-profit non-university hospitals. All must be teaching hospitals and designed to serve all the needs of the people and to consider the whole person as an individual.

A hospital is a special facility, dictated by medical science and experience, to enable the surgeon and the physician to provide patients with the best medical care. It is also the only practical instrument for teaching doctors and training nurses for our communities.

Trustees of our voluntary hospitals are charged with the legal and moral responsibility not only of safeguarding the finances, but also of providing the patients with proper quality of medical care.

The Trustees must necessarily set the policies of the hospital based on the type and quality of hospital desired. Naturally wise Trustees secure proper advice from qualified individuals in all areas of hospital operation.

Hospital Trustees are operating the 5th largest enterprise of the United States.

The administrator of a hospital must operate under the policies prescribed by the Board. In the realm of staff organization the medical staff and its appointed and elected representatives must also operate within the policies prescribed by the Board of Trustees. This is a fundamental point that must be appreciated by all if a hospital is to succeed and progress. The members of a medical staff should feel secure in that hospital Trustees feel deeply their responsibilities and they are giving the time and leadership so essential to meet the unprecedented problems common to the voluntary hospital in this period of world social and economic stress.

The survival of the voluntary hospital and medical practice as we know it today hangs in the balance. A recent article in Philadelphia Medicine entitled "Health Service in England" states:

> "Voluntary hospitals and private medical practice become history in England and Wales on July 4, 1948. The next morning all voluntary and municipal hospitals, with their endowments, plants, movable property, and liabilities, will be vested in the National Minister of Health, who becomes responsible for 'comprehensive health service' for the entire population."
>
> "The voluntary hospitals of England were stifled by the inertia and tradition of their medical staffs and Trustees."

However, progressive American voluntary leadership, coupled with our fine tradition can produce a pattern for the future to meet every health need of our people on the voluntary basis that has been so successful in our Country.

The overall economics of hospitals in general are today under discussion. The per diem cost has advanced, but no more than in other services and commodities. As a matter of fact, statistics presented by Frank G. Dickinson, Ph.D., Director of the Bureau of Medical Economic Research of the American Medical Association, indicate that the people of the United States are today better able to meet today's cost of hospital care than they were able to meet the costs in the 1930's. Americans spent twice as much for jewelry, almost four times as much for tobacco and nine times as much for alcoholic drinks as for hospital care. In the middle 1930's 8/10 of 1% of income was spent for hospital care, whereas in 1945 only ½ of 1% was so spent. It is a paradox, perhaps, that the high hospital rates of 1945 were less burdensome than the low ones of 1933, but it is true. This happens because the country's personal income has climbed even faster and farther than hospital rates have climbed.

continued on next page

* Presented at the joint meeting of the Rhode Island Medical Society and The Providence Medical Association, at Providence, February 2, 1948.

Hospitals must operate on a financial plan that does not dissipate endowments. The Federal tax structure has resulted in fewer large sums being available to assist in meeting day by day financial operation. Government, must, therefore, begin to pay adequately for those members of the community for whom it has accepted responsibility.

This over-all economic problem of present day hospital management must not be allowed to distort our long-term thinking on such fundamental subjects as graduate medical education.

Phases of Graduate Medical Education

Graduate Medical Education, or specifically the training of Interns and Residents, has always been a function of hospitals. The Council on Medical Education and Hospitals of the American Medical Association states:

> "The internship is one of the most important phases of Medical education. Internships designed without a well supervised educational program, or arranged merely to provide hospitals with resident personnel to relieve visiting physicians of tasks which they do not wish to perform, cannot be approved.
>
> *Basis of the Internship:* The internship is a form of apprenticeship. The intern assists in the care of patients and receives in return instruction from the hospital staff in the clinical and laboratory aspects of his profession."

The report of the Commission on Graduate Medical Education, published in 1940, says in connection with Interns:

> "The internship, which is designed to round out and unify the physician's undergradute education as this applies to actual practice, by its very nature requires close supervision of a definitely educational character. This implies that the intern's teachers will be concerned primarily with aiding him to understand the patient as an individual and to appreciate the painstaking nature and vital necessity of a good history and physical examination leading to an accurate diagnosis. The teachers should not lay stress upon the detailed technics of the specialties, even though in some instances these may be the most dramatic elements in the care of the case.
>
> Improvement in its educational content is today the most important problem of the internship and one of the most important in the whole field of medical education. This educational content should be a vital factor in determining a lifetime habit of study. Obviously no formal course of didactic lectures or of laboratory opportunities is going to create automatically a genuine and continuing interest in self-education when no such interest exists. Such an interest must be either born in a man or created by his contacts with great minds. When such an interest has been created during medical school days, the internship should do everything reasonably possible to nurture and to stimulate it.
>
> The internship and residency offer to hospitals the best opportunity to inculcate in the physician of the next generation an understanding and appreciation of the need and value to him and his patients of hospital procedures and routines. If this opportunity is missed, some hospital may be forced to work with an unsympathetic staff man for twenty-five or thirty years."

What does the hospital offer the intern in the way of further opportunities to study and to learn medicine? This question is well answered in "Medical Education and the Changing Order" by Raymond B. Allen, M.D., now President of the University of Washington and published in 1946 under the auspices of the New York Academy of Medicine, and I quote:

> "First and foremost it affords an ideal opportunity for him to apply and develop his knowledge and skill in diagnosis and treatment under the watchful eyes of experienced physicians. Thus he takes another carefully supervised step toward independent responsibility for the life and welfare of patients. It is this kind of experience for which the eager student of medicine has been striving ever since he decided to become a physician. If his undergraduate education has been sound and inspiring, and if during his internship he has the good fortune to come under the influence of good clinicians who like to teach, a vital education experience is assured. In the absence of either of these elements, that is, an eager well-educated student and an experienced clinician who enjoys working together with students, any amount of organization, rules and regulations, required lectures and seminars, reports and grades will fall far short of anything like the ideal.
>
> There is little doubt that some internships fail even to approach such an ideal. The fault lies with medical schools which select students poorly adapted to medicine and then fail to provide an adequate medical education, and with hospitals which do not recognize that the internship is an important, indeed critical, part of their responsibility to patients and to the whole educational process. Hospitals which fail to perceive their role in medical education and think that they have discharged their obligations to the intern by providing suitable living quarters, recreational facilities, perhaps a small stipend (in general, the poorer the internship the larger the

stipend), an opportunity to write histories and do physicals, make hurried rounds with a busy practitioner, hold retractors at operations, and carry out other routine functions, have no place in any plan of genuine internship education. The spread between high-quality educational internships and those which merely satisfy formal, so-called minimum requirements is very wide indeed. A regrettable aspect of the whole situation is that the weaker students often have no alternative but to take the poorer internships, thus further complicating an already difficult educational problem. The internship experience should strengthen, not weaken, the student's appreciation of high scientific and ethical standards of practice. The quality of staff and interns determines the quality of the internship, just as the quality of faculty and students determines the quality of an undergraduate teaching program.

Gradually it has become evident that rotating internships were degenerating into a merry-go-round of kaleidoscopic impressions of medical practice with undue emphasis on its technical aspects, and it is now generally recognized that the internship should be concerned primarily with the study of patients as persons, the natural history of their diseases, and the appropriate regimens of treatment. With the patient as the unit of study, the internship is gradually being reoriented and rearranged so that interns can broaden and deepen their knowledge of men by studying them intensively when they are sick."

These quotations represent selected sections from three publications all of which are the results of study by recognized national leaders in medicine and medical education.

Internships in New England

The Medical schools of this country, 77 in number, have a budget in 1948 of forty-three million dollars and with fees from students of but twelve million. In other words, the average cost per medical school student per year is about $1,700, whereas the student payment is about $500 per year. These schools are both charitable and governmental. The remaining funds, therefore, come from endowment, contributions, and from tax sources.

There are 24,000 medical students with 5,716 to graduate in 1948. Of these 1,549 are enrolled and 397 will graduate from medical schools in New England this year. It is conservatively estimated that 50% of the 4 years in medical school is spent in some 300 hospitals. These young men of medicine, after completing medical school then receive their graduate medical education in more than twice as many hospitals.

There are 6,280 hospitals in the United States registered by the American Medical Association with but 764 approved for intern training with a total of 8,539 approved internships. A study of approved internships in New England reveals that:

89 7/10 per cent of New England Hospitals approved for internship training are voluntary hospitals.

72½ per cent of interns trained in New England are trained in voluntary hospitals, the remainder in government hospitals.

New England Hospitals in general must, therefore, attract graduates from medical schools outside of New England as there are 286 more internships than men seeking them.

This presents a great challenge to the New England non-university hospitals as not only are there more internships than interns in New England, but also throughout the country. With 50 per cent more internships than interns, the competition for interns is naturally keen.

Hospitals are competing in the realm of training programs.

Voluntary Hospitals Lead in Education

This data demonstrates that a very high percentage of graduate medical education as well as the portion of undergraduate medical education carried on in hospitals is carried on in the voluntary non-profit type of hospital.

This establishes the fact that as the public, through contributions and payments for hospital service, has financed the voluntary hospital so the

continued on next page

From American Medical Association August 16, 1947

State	Hosps. Approved	Internships Approved	Voluntary Hosps.	Voluntary Internships	Government Hosps.	Government Internships
Massachusetts	39	417	33	241	6	176
Rhode Island	4	42	4	42		
Connecticut	18	185	17	173	1	12
Maine	4	21	4	21		
Vermont	2	9	2	9		
New Hampshire	1	9	2	9		
TOTAL	68	683	61	495	7	188

public has paid the cost of the great volume of medical education that has been and is being carried on in the voluntary hospitals of this country.

Medical school faculties know the hospitals where a good intern training program is available. Young men in training pass the word along. Their criteria is the educational program as applied to this level of graduate medical education.

The factors used by the AMA and ACS in determining approved hospitals are the very items which the faculties and the medical students value. The percentage of autopsies, the kind of staff structure, the scope of laboratory and x-ray departments as indicated by statistics in comparison with patient days of service, the number, kind and quality of scientific meetings, the quality of medical records and the scope of professional audit—these factors which you men know so well, are the factors that mean so much to prospective interns when they are selecting the hospital in which to pursue their graduate medical education.

The national bodies referred to above have done much to improve the quality of American hospitals both as to service to the patient and education. It is natural and proper for Hospital Trustees and Staffs to wish to live up to the minimum standards required. The leading hospitals in the country naturally forge far ahead of the minimum standards.

Trustees in selecting men to head up medical departments must naturally give consideration to many factors if the hospital is to have leadership, not only in the individual care of the patient, but in the graduate medical education program which is a necessary adjunct to patient care.

In our own State of Rhode Island there are four hospitals approved by the American Medical Association for intern training and all are voluntary non-profit hospitals, namely:

Memorial	6
Rhode Island	24
Roger Williams	6
St. Joseph's	6
TOTAL	42

As there is no medical school in Rhode Island, it is necessary for these four hospitals to look to medical schools in other States. However, this is also true of certain other States in New England and other areas.

The Resident Training Program

The medical profession of this country, appreciating the growing complexity of modern medicine and realizing the need for a special training in certain areas of medicine set up Resident Training Program.

In Rhode Island, exclusive of Psychiatry and Tuberculosis, there are twelve Residents graduated per year.

The Master Plan of the Hospital Council of Greater New York calls for a resident training program to produce specialists in direct relation to the needs of the people. The Rhode Island Resident Program, after making adjustments for variance in population is producing but ½ of the requirements set by this New York Plan.

The compactness of our State and the small number of hospitals participating in this graduate education program together with the presence of several Colleges should make possible a fertile field for successful internships, residencies and a program of continuing education of the practicing physician.

The use of several hospitals in rounding out a resident program is practical as demonstrated by the Residents in Pathology at the Rhode Island Hospital who gain experience by activity in 6 different hospitals of the State.

This could be followed in other specialties if through staff organization selected staff members of the participating hospitals could be integrated in the over-all teaching program of the central hospital. It cannot now be worked out on the intern level except for affiliation to round out training for general practice. The general and specialty hospitals of this area by joint effort could do an outstanding piece of work in training men for general practice.

The four Rhode Island Hospitals approved for Intern training will secure interns only if an educational philosophy prevails within the hospital. This will require a desire to teach on the part of the medical staff; support of the program by the Trustees, not only moral support, but adequate financial support and leadership by the Administration of the hospital.

The organization and direction of the internship program by the Hospital Administrator is just as definitely an obligation as is the organization and direction of the undergraduate medical teaching program by the administration of the medical school.

Relation to Hospital Economics

How does all this relate to the hospital economics? Should the patient pay for the cost of the intern and resident training program?

There are not many who have raised this question and there is not agreement that the point should be discussed.

It is an acknowledged fact that graduate medical education is an integral part of patient care. It cannot function without patients. Patients who participate receive a better quality of care. A hospital with an educational program provides better

care to all patients. Without education the hospital cannot progress. The chief gainer when the hospital becomes a teaching hospital is the patient. Dr. Alan Gregg of the Rockefeller Foundation has said: "Teaching is the greatest service and safeguard to the patient which a hospital can provide."

Let us examine briefly the cost to the hospital for intern training. These costs are both direct and indirect.

The direct cost analysed at the Rhode Island Hospital includes housing, meals, uniforms, laundry, hospital care when ill and stipend—for residents only.

The indirect costs are represented by the greater use of hospital supplies, x-ray and laboratory facilities, additional diagnostic and therapeutic procedures, more demands on nursing and technical personnel, library and record department. These factors deserve full consideration when we evaluate the role of the hospital in the educational field and when hospital budgets are prepared, although it is impractical to attach a dollar value or cost, rather it must be interpreted as an investment of the hospital in good training for young physicians. The best service that can be rendered a community by its hospital is contributing to the caliber of its future physicians. However, the visiting physicians have the responsibility of supervising and, yes, of controlling these indirect costs. The use of costly tests without a medical, educational, or research need is an economic waste that must not be tolerated. At the same time those who pay for patient care must appreciate that these indirect costs are proper educational expenses and in the interest of the patient.

There is another aspect more important than these—the contribution of staff members to the education of these young men. You physicians of medical staffs are making one of your many and great contributions to society and to the progress of medicine when you do a thorough and thoughtful job of training your successors.

This contribution is not expressed in dollars as the teacher in medicine gains much from contact with the inquiring minds of young men of medicine. However, it is fair to say that less than ½ the potential cost is all that is being considered when we raise the question: "Should the patient pay the cost of intern and resident training?"

However, let us view the facts of dollar cost for the direct expense to one hospital. The cost of the intern and resident education program at Rhode Island Hospital last year was $67,000, or 2 3/10 per cent of the total operating expense.

The direct cost per intern per year is $1,204.80 and per resident $1,923.70. The indirect cost would add approximately $500 per man per year.

The patient contributes to the education of interns and residents and, if the educational program is well carried out, the patient enjoys and values it. By the same token the intern and resident make a real contribution to care of the patient. A spot check study at Rhode Island Hospital indicates that the average patient receives a minimum of 6 hours of service from an intern during the average hospital stay. A good history and physical requires one hour; surgery requires nearly one hour for pre-operative and over one hour for the operation itself; daily visits, dressings, notes on chart and discharge summary consume another three hours. Many major surgical and involved medical cases require additional hours of attention. A recent consultation at Rhode Island Hospital utilized for 20 minutes the undivided attention of 17 physicians.

The cost per ward patient per day for intern service at Rhode Island Hospital is 61¢ of a total cost per ward patient day of $14.50. Statistics as to utilization of hospitals indicate that about 10 per cent of our people go to our hospitals in a given year. In other words, we might say that once in 10 years each of us is in need of hospital care. The payment of our proportionate share of graduate medical education through a charge for hospitalization, particularly when we have direct benefit, could not by any stretch of the imagination be considered unfair.

Is not continuity of attention, guarantee of continuous availability of medical service within the hospital and out in the community, plus the detailed service per patient as has just been described worth 61¢ per day to the patient?

These hospitals that we have been discussing have certain endowment funds. Some may say charge the cost of graduate medical education to the income from endowment. In other words, use the endowment income to finance the graduate medical education program.

Yes, this may be done, but it will merely be a bookkeeping entry as less funds will be available to meet other patient needs.

In other words, the present procedure is for graduate medical education to be absorbed in general hospital costs and applied to all patients, although many hospitals have erroneously neglected to charge the private patient a fair share.

The major portion of graduate medical education is being carried on in the voluntary hospitals. However, we must not overlook the contention made by Government hospitals such as the Boston City Hospital and the great municipal hospitals of New York City. The quality of our non-profit hospitals results in major part from the educational function so well carried out. We do not wish to sacrifice the quality of our voluntary hospitals by forfeiting to government hospitals the

continued on next page

educational function. Whether we buy an automobile, a radio or a bar of soap we pay for the education and research that has gone into the production.

SUMMARY

If we are to continue to improve the quality of service to the sick, we must safeguard the financial structure of our voluntary hospitals and we must accept the fact that graduate medical education is an integral part of patient care.

Originally, young men of medicine paid for experience in a hospital. However, the great bulk of graduate medical education in this country has been financed by the supporters, including the patients, of the voluntary hospitals. It is a fundamental fact that graduate medical education and patient care must go hand in hand and thus the hospital is the only practical instrument for teaching doctors.

Present-day hospital costs are the result of the progress of medicine as much as the result of price spiral. These present-day hospital costs are, therefore, probably here to stay and, because of the lack of understanding of these costs and our general social upheaval, the question as to the proper procedure comes up for review.

Who should pay for graduate medical education? The decision can be selected from the following possibilities:

1. The intern, by paying tuition.
2. Government to finance by concentrating this activity in Government Hospitals.
3. Philanthropy or endowment by specific educational grants.
4. The patient or third party payee such as Blue Cross.
5. Or, we can follow our present system whereby the patient and philanthropy share the cost.

Although the answer seems obvious to many, it is apparent that there is need for clarification of this important subject of graduate medical education and hospital economics. This topic warrants the careful and judicious thought of groups such as the Rhode Island and Providence Medical Societies.

POSITION OF THE GENERAL PRACTITIONER TODAY

concluded from page 170

It is to be hoped that these adjustments which have been made necessary by the changing order will restore to the general practitioner his rightful place within a medical profession in which no one group dominates but in which all are united for a common purpose — the best possible care of the patient.

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THE RHODE ISLAND COLLEGE OF PHARMACY

In the early days of medicine the compoundings of drugs and their administration to the sick were accomplished by the same individual. The old time physician and apothecary were one. At the present time not only does the doctor find his own profession broken up into a group of specialties but he recognizes pharmacy as a separate and allied profession on the achievements of which he is dependent for much of the wherewithal that he requires in the application of modern treatment. Both medicine and pharmacy have gone a long way and the elaborate technics involved in their work make necessary a diverse and specialized training for each.

The Rhode Island College of Pharmacy, which graduated its first class in 1903, is now conducting a drive to raise funds for a building adequate for its needs. This effort deserves the hearty support of the medical profession. As allies of the physicians of our state the graduates of this institution have carried on their work with skill and integrity which justifies the confidence of all our citizens. The standards of their training are high and they share with us of the medical profession the lofty ideals of service which should govern the care of the sick throughout the civilized world. They work in many fields including not only that of the prescription pharmacist but also as workers in the laboratories of Health Boards and in the broad field of pharmaceutical research.

With the recent advances in therapy, particularly in the field of chemotherapeutics and antibiotics and also along other lines as well, no doctor need to be told of his absolute dependence upon those who prepare and furnish to him the various medicaments which he must use.

It is with pleasure, then, that the JOURNAL extends to President Claflin and his co-workers congratulations on their accomplishments in the past and the hope that their present efforts will lead to the means of still greater achievement in the future.

WOMEN PHYSICIANS

For the second time within three years a district medical society in Rhode Island has honored a woman physician with its presidency. In 1945 it was Washington County that named Dr. Frances A. Kenyon as its leader. In 1948 it is Kent County to the fore with Dr. Jeannette Vidal.

The honor to Dr. Vidal is particularly significant in view of the fact that the Kent County Society has taken leadership in the campaign for a hospital in that area, and with the fund raising phase of the program being launched this month the president of the district medical society is certain to draw added important duties. That Dr. Vidal is well qualified for her post cannot be denied. She served as an active member of the committee on public laws of the state medical society for two

continued on next page

years, and she has been the efficient secretary of her county society during the same period of time.

It is just such action as this naming of capable outstanding women physicians to position of organization leadership that demonstrates one distinguishing feature about medical groups. When work is to be done the task is to the willing and the capable, and politics and sentiment are relegated to the background.

To our loyal women physicians in Rhode Island, headed by Dr. Margaret Hardman who was honored at the recent Providence Medical Association Centennial for her distinguished service as the oldest living member of that society, the Journal points with great pride.

CENTENNIAL

The celebration of the Providence Medical Association went off in a wonderful manner. The committee in charge headed by the President, Dr. Philip Batchelder, and aided by the executive secretary, who, as Dr. Batchelder said, might appropriately have received along with his doctorate a master's degree — Master of Detail — made so far as we know not a single slip nor left anything worth while undone.

The Wyeth Corporation kindly lent their series of historical medical paintings by Dean Cornwell which were displayed in commercial establishments. The prize poster by which Mr. Adolph Jeff won the competition among School of Design students was of course prominently displayed throughout the city.

One of the chief features incorporated in this was the seal of the Providence Medical Association which was designed by Mrs. Howard D. Day seven years ago. It most appropriately depicts Roger Williams and a companion being greeted by Indians as they landed here. Entwined about this are formalized serpents of Aesculapius. The wording is in keeping with these days when the classical languages are decidedly in the discard.

We have not heard a dissenting voice regarding the excellence of the dinner and meeting on January 31, the hundredth birthday date. An efficiency engineer could not have found room for more in the dining hall. The hotel outdid itself in the quality of food and service. The liquid refreshments produced just the desired effects and no more. The state and city executives were graceful in their oratorical offerings.

Dr. Ruggles, the President of the State Society, presented certificates to the past and present officers with an urbanity and light touch that made the ceremony pleasing to the onlookers as well as to the recipients of awards. A surprise feature was a reproduction of the original meeting of the Association. The bewhiskered and frock coated members were highly diverting if not familiar to the modern audience.

Having reported all this with genuine enthusiasm we are now moved to some decidedly adverse remarks. The highlight of the entire celebration was, as it should have been, the talk at the medical library in the afternoon by Dr. Reginald Fitz of Boston. Dr. Fitz paid us a great compliment. He did an enormous amount of work to become acquainted with our history and carry through research on obscure points.

But Dr. Fitz is no Jonas Dryasdust. His talk was as bright as Joseph's coat of many colors. As it is printed in this Journal, you will see the firm warp on which he embroidered a brilliant woof lost now except in the memory of the fortunate few who attended. Four hundred and twenty-five people came for the food and drink at the hotel. Possibly one-fifth of these had the far richer feast Dr. Fitz furnished. As Sam Weller's old lady said when she kissed the cow, "Everybody to their own taste."

Congratulations to the Providence Medical Association as it starts with a rush for 2048.

TRUTH AND CIRCUMSTANCES

"A man must not always tell all, for that were folly: but what a man says should be what he thinks, otherwise 'tis knavery."

MICHEL DE MONTAIGNE

There are certain perennial ethical questions, not usually covered in formal medical curricula, which confront each new crop of physicians. Sometimes they are incidentally, and somewhat casually, discussed in the course of clinical instruction. Sometimes they are not even mentioned. One of the most important of these questions relates to the discussion beween patients and practitioners concerning their ailments after such examinations as are necessary to reach a diagnosis have been completed. The subject has been discussed from time to time in medical essays or books, by Alvarez, for example, in his "Nervousness, Indigestion and Pain." The problem can be summarized in a few words: shall the physician always tell the patient the truth regarding his illness even though it be a serious, perhaps a necessarily fatal, one?

There are several factors to be considered in attempting to reach a conclusion as to the general principles which should govern this situation. In the first place it is fair to point out that, as the result of inherent difficulties in diagnosis, the physician does not always know the truth and that, even in the simplest case, he can but express the truth as he sees it, inevitably colored by his judgment and his personality. Then again, to use the well-known legal phrase, should he tell "the truth,

the whole truth, and nothing but the truth" or should he, in certain circumstances, shade or euphemize his statement to the patient?

From the ethical point of view there are cogent reasons why physicians should be frank and open with their patients. As Francis Peabody once said: "the essence of the practice of medicine is that it is an intensely personal matter," and it is difficult to conceive of patients maintaining satisfactory personal relations with doctors who are habitual liars. Even though it be true, as the psalmist said, that "all men are liars", he admitted that he made the statement in haste and many men indulge in mild social fibs only and would scorn habitual deception in matters of such vital importance as health. Mutual confidence between physician and patient is often an essential element in securing the best therapeutic results, even in these days of specific therapy, not only because of its psychic effect but also because, in intelligent patients, better cooperation is obtainable if the person under treatment has clear insight into the nature of his trouble. Nor should we overlook perhaps, in a discussion of this kind, the detrimental effects on the character of the doctor who pursues a policy of habitual mendacity.

The reason for shading the truth or using euphemisms in some cases is a psychological one. There are many nervous patients who react unfavorably to the plain, unvarnished truth, mainly because certain diagnoses have come to have an ominous significance to the average or even the highly intelligent among the laity. To bluntly tell a nervous patient that he or she has a cancer or angina pectoris may result, as I have personally observed, in rapid downhill progress in the case of a neoplasm or the development of an anxiety psychoneurosis in a patient with coronary disease. Furthermore not all patients desire to hear the naked truth and some of them are not sufficiently intelligent to grasp its implications. On the other hand some patients insist that they be allowed to face the facts and such requests should be granted, albeit the subject should be presented with tact and sympathy. After all, in the presentation of truth the manner is often as important as the matter. Some of the older readers may recall that once popular Cockney song of Albert Chevalier the refrain of which was "it ain't exactly wot 'e sez, it's the nawsty way 'e sez it." Needless to say, the family should always be told the whole story. We may well sum up the matter in the words of Mark Twain: "When in doubt tell the truth."

G.B.

KENT COUNTY HOSPITAL

For the next few months an active campaign will be in progress to raise $800,000 to finance the erection of the Kent County Hospital to be located on Toll Gate Road, midway between Westcott and Apponaug. The campaign comes in the midst of a period when the public generally is under solicitation for many worthy charitable causes, and at a time when experts note a decided decrease in the size of contributions.

A campaign to erect a hospital is more than a mere contribution for a worthy charitable cause. For the people of Kent County the hospital is a vital investment in community health and welfare, an investment that ranks equally with the school, the fire, and the police systems.

The excellent state highways that have enabled the city worker to move his residence outside the Greater Providence area have also encouraged the policy of speeding the patient needing hospitalization to the institutions within the City confines, thus furthering the overcrowding of them. It is encouraging, therefore, that the city of Warwick and its surrounding towns have accepted the responsibility for providing a hospital local to Kent County.

The area to be serviced has grown in stature in recent years. An estimated 60,000 persons reside within the County. Even the County Medical Society has noted a decided increase in membership with thirty-four physicians now on its roster, a fine nucleus for the staffing of the new hospital.

In an era when philanthropy is laid low by taxation, when other states look to the federal government for funds to meet local expenses, the voluntary process is tested again in Rhode Island. We are sure that people throughout the state will join with the citizens of Kent Couny in generous support of their hospital program.

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ADMISSION TO MEDICAL SCHOOLS*

DWIGHT O'HARA, M.D.

The Author. *Dwight O'Hara, M.D., of Boston. Dean, Tufts College Medical School.*

WHEN I RECEIVED this assignment I went to the chairman of our Admissions Committee, asking him what he thought I ought to say. He replied that there really isn't much to say on the subject of admission to medical schools; either you get admitted or you don't, and that's all there is to it.

* * *

In its present form the professional aptitude test used by the Association of American Medical College is one year old; in the medical schools we are now dealing with the second generation of those tested. We consider it an improvement over previous aptitude tests, but it is still a test that tends to determine facility of memory and past exposures rather than creative or constructive ability. One of the members of our Admissions Committee has been curious enough to take this test—(I am sorry I am not free to divulge what the scores indicated concerning this individual, but you might be surprised, as he was, by the implication of what the college senior is expected to have packed away by the time he applies to enter medical school). After taking the test, our faculty member gave us this tip — which I am glad to hand on to you — that the best possible preparation is to faithfully read every copy of the Reader's Digest for the past ten years! He does not think that this will insure a high score, merely that it will help in preventing one that is too low.

In general aptitude tests are disappointing because they cannot approach a given vocation with the infinite variety of aptitudes which individuals seem to bring to bear upon the same vocation in practice. The truth is that not one, but many aptitudes are applicable to most vocations; too many to test with any prognostic finality. I do not mean to imply that we do not consider the aptitude test as a distinct help in reaching decisions. We try to make it confirm the other evidence presented by each individual applicant, and it frequently does this in a very satisfactory manner.

It is generally thought that a first degree insures a certain amount of culture, as well as the scientific preparation for the work in medical school. This is what we all hope, and it is probably a fact that a college training does insure a broadly cultured individual insofar as anything can insure that desirable product. There has been a good deal of discussion about this among medical educators, but I believe they might better approach agreement in their views if they could confine themselves to a consideration, not of whether their candidates have acquired "culture" or been "educated", but whether they have sufficiently *matured* to be able to adapt themselves to the study of medicine. Maturity is used here to describe a combination of seriousness and wisdom that comes with the passing of time; to some it comes early, to others late. We have now seen many instances in which maturity did not appear in a good college environment, but quickly came when the individual left that environment to enter the rough and tumble of military service. Some people never mature, regardless of age or academic or other exposures. Because an arbitrary standard has to be set somewhere we feel that the academic exposure necessary to qualify a person for the first degree is a good requirement to apply to the large number of present day applicants. As always there are conspicuous exceptions, and our Admissions Committee may permit special conditions to apply to special cases; in general however it sticks to the requirement of a degree and selects its students from among applicants who expect to receive a degree with the completion of their premedical work.

What courses to elect other than the orthodox English, Biology, Chemistry, Physics and Language is not important. At Tufts we also require an elementary course in Psychology. This is sometimes accounted for by the fact that the President of Tufts College is a psychologist, but the psychology requirement was instituted by Dean Stearns before President Carmichael assumed his present position, and was based on Dr. Stearns' belief that an elementary insight into normal motivation and reaction is essential to an understanding of the behavior of the sick. Many seem to think that a

continued on page 188

* Excerpts from a lecture presented at Brown University, Providence, on January 6, 1948, as part of a series on Medical Education offered by the Department of Medical Sciences.

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ADMISSION TO MEDICAL SCHOOLS

continued from page 186

mediocre scholastic performance in the sciences may be counteracted by a large volume of science courses, but this is not so. Straight B grades in anything are preferable to C grades in a top-heavy scientific program. After one has corrected a batch of examination papers he is inclined to agree with the chemistry professor who said he didn't care what subjects were required for premedical study, if only the students could be taught to read and write the English language. Certainly there are plenty of graduates of both colleges and medical schools who are illiterate in the sense that they express themselves awkwardly. Today the doctor is being forced into a position of leadership which requires him to be able to utilize to the utmost this medium of expression upon which we must depend to make ourselves understood. In matters of health the doctors should be the leaders.

The power of properly used English not only to express opinion as it may relate to pertinent facts and procedures, but scientific wisdom as well, is an essential tool if the doctor is to shape the conditions under which optimum health can be attained.

* * *

I notice that previous lecturers have talked of medicine in the present and future. If you will excuse me I would like to speak of yesterday in terms of my own experience. Previous to graduating from medical school I had always intended to practice general medicine, but four years in a school in which I didn't see a single general practitioner frightened me enough to form a loose partnership with a colleague who had had a surgical training. Between us we were self sufficient. In the twenties we thought we knew all there was to know.

I look back upon that decade as the period in which I learned more, per year and per unit of effort, than was the case either before or since. We learned things about medicine that were not in the books and that were contrary to the authoritative statements of the day. We discovered what appeared to be new diseases; I recall one the blood specialists of the early twenties knew nothing about but which we later found had been beautifully described as "Puerperal Anhemia" in 1842 by Walter Channing. A single text, the Principles and Practice of Medicine, by Osler was our Bible; in it we seldom failed to find an answer. I recall a tracheotomy on a kitchen table, visiting homes on snow shoes, post morten examinations in the master bedroom and other incidents of a medical life that has all but disappeared, even in rural regions. Indeed, in many rural areas now all medical life has disappeared. We learned a great deal from older doctors; men who were already what we thought to be a little old fashioned, but who had had years of experience with sick people. When the adjective *psychosomatic* was recently coined I had difficulty in understanding why it suddenly seemed a popular thing to talk about, because in the twenties it was what every doctor knew. The reason an old concept could thus be suddenly popularized was that a whole generation of doctors had been carefully shielded from knowing the ordinary facts of life by intensified attention on the part of their teachers to the reactions in test tubes and experimental animals. It is so apparent that something has thereby been lost that I would like to make the point that we should not turn our backs upon the past.

* * *

The art of understanding people and the complex situations in which they find themselves is not an easy one to acquire. It calls for much hard work. The doctor must be a person who is willing to do this work, not one who seeks to find an easy answer. The doctor is now being called upon to be a sociologist as well as a physician in his outlook. The narrow fields now being cultivated in medicine, surgery or any of the specialties are not broad enough to retain a full professional status for their practitioners. Without a social point of view these specialties are trades.

Look at this great atomic threat under which we now live from day to day! The scientific teams which made the bomb have already turned to the medical profession to justify the prodigious cost to which they have committed mankind. One seldom hears this frightening subject referred to without the ameliorating sop that we can learn to use our knowledge to *save* life instead of destroy it. It has even been stated that already as many lives have been saved by this knowledge as were lost at Hiroshima. This is of course ridiculous; the fact is that we know next to nothing about the beneficent aspects of this knowledge; we hardly know how to protect ourselves against accidents in its use. Here is a challenge however that medicine must meet if it expects to remain a profession. Can such a challenge be met? If it can it will be not by the doctors of today but by the oncoming generation, by those who are today being admitted to the medical schools of the country. The medical schools are recruiting the profession of the immediate future, which brings us back again to the subject of the evening.

I hope you will not feel that I have put myself on one side of a fence and you on the other for that is not the spirit of the medical schools and of course it is not the purpose of this meeting. Perhaps I can be most useful by giving you a few suggestions, and then try to answer questions.

continued on page 190

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*Barr, Joseph S., *Ruptured Intervertebral Disc and Sciatic Pain*, Jr. Bone and Joint Surg., 29: 429-437 (April) 1947.

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ADMISSION TO MEDICAL SCHOOLS

continued from page 188

Although a certain degree of scholastic proficiency has to be demonstrated, none is admitted on grades alone; the medical schools try to secure a composite impression of their candidates. Admission committees will be interested in your background, your physical condition, your general appearance and behavior, your age, your past experience, your nervous stability, your professional aptitude and graduate record examination scores, what courses you elect and why, your extra-curricular activities, the opinions of people who have really had an opportunity to know you (not your back slappers), your status as a veteran, whether you are married and if so what your financial planning is, your own reasons for wanting to study medicine, the legibility of your handwriting, or anything else that may help them to see you as a complete individual.

Most medical school admission blanks call for a passport type of photograph. Be careful about this. We are not all "photogenic", and a camera may or may not give a good impresson; don't use a picture that gives a poor impression. If you are asked to appear for an interview it will probably mean that acceptance of your application has already been carefully considered. It is possible to make a poor impression at an interview, by sloppy clothes, by cocky manners, by assumed attitudes and sometimes perhaps by just being frightened and nervous. The interview is not an examination; you need not prepare for it in any way. Go to it as you would go to church, or as you would go to call upon your best girl friend; just be natural and straightforward. If you are a natural and straightforward person, can get along with your associates, are nervously stable and can do B grade work on a full sized academic schedule, you are the kind of person the medical schools are interested in. Whether they will be interested enough for one of them to accept you will depend upon how you measure up in the competition. It is a competitive profession in a competitive world.

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DISTRICT MEDICAL SOCIETY MEETINGS

KENT COUNTY MEDICAL SOCIETY

The annual dinner meeting of the Kent County Medical Society was held at the Greenwich Club, East Greenwich, Rhode Island, the evening of December 9, 1947.

Following an excellent turkey dinner the meeting proper was called to order at 10:15 p.m.

Dr. John Mack read the yearly treasurer's report and noted that a few members of infrequent attendance were delinquent in dues for two or more years. Upon this information a motion was carried that the secretary notify the physicians concerned that they are automatically suspended and are not eligible for reinstatement until dues are brought up to date. It was further decided that physicians so delinquent who are also members of the state society or hold hospital appointments shall be reported as members not in good standing locally to the state society and the hospitals concerned.

Retiring president, Dr. Peter Erinakes, presented a paper entitled, "What Does the Future Hold for the General Practitioner." In it he noted that to retain the prestige of the family doctor the present day general practitioner must modernize his methods of diagnosis, therapy, and equipment and choose a faithful and efficient staff to aid him.

Officers for the year 1948 were then elected and consist of the following:

President:	JEANNETTE E. VIDAL, M.D.
Vice President:	JOSEPH K. HARROP, M.D.
Secretary:	FRANCIS D. LAMB, M.D.
Treasurer:	JOHN A. MACK, M.D.

It was decided that remaining committees and chairmen for the coming year would be selected at the January meeting.

Dr. Erinakes offered the continued use of his office for society meetings. A rising vote of appreciation was extended him for past use and his offer was accepted.

A final motion was carried that the secretary send the list of active members to Mr. John E. Farrell, executive secretary of the Rhode Island Medical Society, for the purpose of considering one as an additional delegate to the state medical society. The meeting adjourned at 10:45 p.m.

* * * *

No formal January meeting of the Kent County Medical Society was held because of generally inclement weather.

A guest speaker, Dr. Harry L. C. Weyler, gave an interesting talk on "Heart Sounds and Their Clinical Significance," to a small group of members who attended an informal gathering the evening of January 13 at Dr. Peter Erinakes' office.

FRANCIS D. LAMB, M.D.
Secretary

NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport County Medical Society was held at the Newport Hospital on Tuesday evening, January 27, 1948.

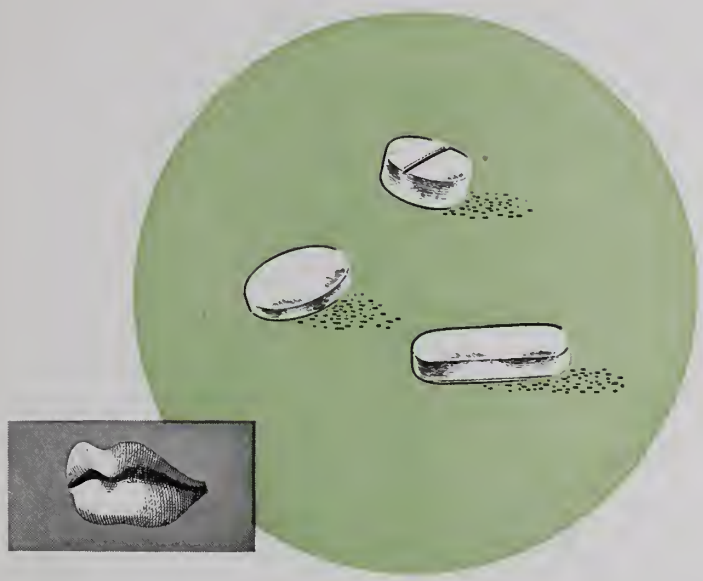
The meeting was called to order at 9:00 p.m. by Dr. Alfred M. Tartaglino, President.

The minutes of the December meeting were read and approved.

continued on page 195



JEANNETTE E. VIDAL, M.D.
President, 1948
KENT COUNTY MEDICAL SOCIETY



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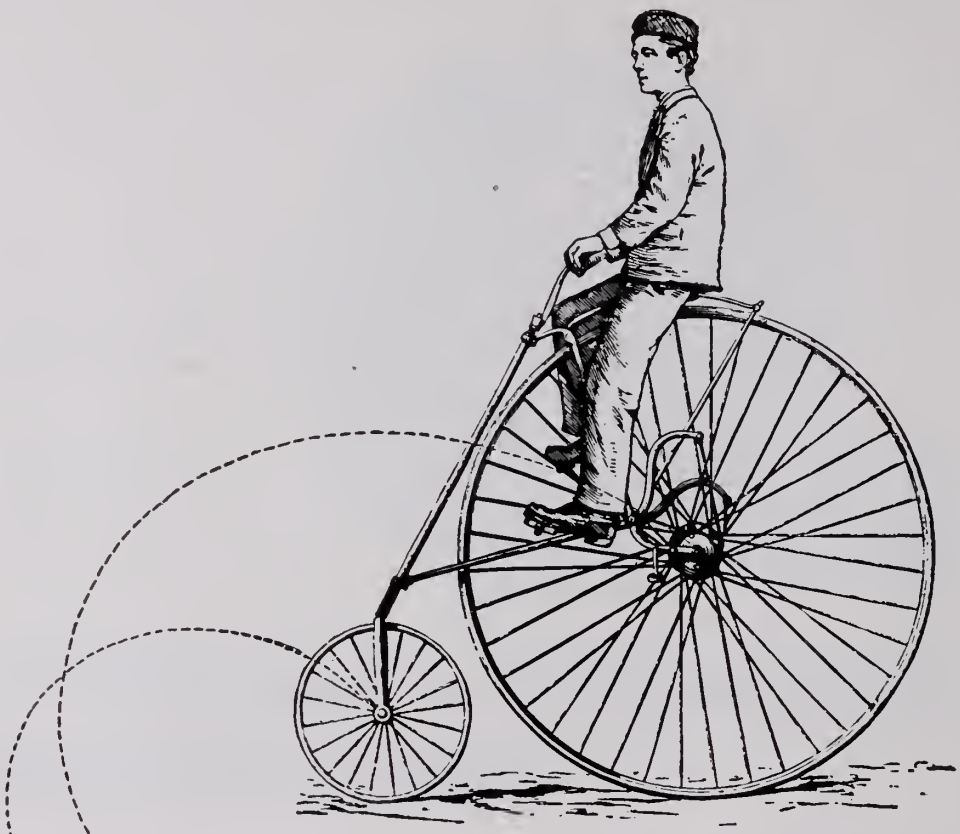
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NEWPORT COUNTY SOCIETY MEETING

continued from page 192

A communication was read from Mr. John E. Farrell, Executive Secretary of the Rhode Island Medical Society, regarding the attendance of delegates at meetings of the House of Delegates.

There being no old business, the election of officers was then held and the following officers for the coming year were elected.

President.....PHILOMEN P. CIARLA, M.D.
First Vice President.....HENRY W. BROWNELL, M.D.
Second Vice President.....ROBERT L. BESTOSO, M.D.
Secretary.....JOHN M. MALONE, M.D.
Treasurer.....NORBERT U. ZIELINSKI, M.D.
Delegates.....JAMES C. CALLAHAN, M.D.
LOUIS E. BURNS, M.D.
Councillor.....SAMUEL ADELSON, M.D.
Censors.....NORMAN M. MACLEOD, M.D.
JOHN A. YOUNG, M.D.

The speaker of the evening, Dr. Herman Lawson of Providence, was then introduced. Speaking on "Splenomegaly," he discussed some of the causes, complaints, physical findings and laboratory data in patients with a mass in the left upper abdomen. He mentioned numerous helpful diagnostic aids which might aid in the differential diagnosis of patients with an enlarged spleen.

Following the question and answer period, a collation was served.

Respectfully submitted,
HENRY W. BROWNELL, M.D.
Secretary

PROVIDENCE MEDICAL ASSOCIATION

A joint meeting of the Providence Medical Association and the Rhode Island Medical Society was held at the medical library on Monday, February 2, 1948.

The meeting was opened by Dr. Arthur H. Ruggles, President of the Rhode Island Medical Society, who reviewed the history of the Dr. Charles V. Chapin medal awards. He reported how the city of Providence had in 1943, two years after the Rhode Island Medical Society had instituted the lectures and had heard orations by Dr. Timothy Leary, professor of pathology, emeritus, of Tufts Medical School, and Dr. Edwin H. Place, professor of clinical pediatrics at Tufts Medical School.

Dr. Ruggles announced that medals had been provided now for the first two orators. He then introduced the Honorable Dennis J. Roberts, Mayor of Providence.

Mayor Roberts briefly reviewed the contributions of Dr. Chapin in the field of public health and cited the debts that the city of Providence and the Chapin Hospital, as well as the medical profession owe to Dr. Chapin. He reported the action of the City Council of Providence in enacting an ordinance to establish the Chapin medal award, and he expressed his personal pleasure in being privileged to present the medal on this occasion to Dr. Edwin H. Place who gave the oration on June 2, 1943, and also, in absentia, to Dr. Timothy Leary who gave the first oration on June 3, 1942.

Dr. Place accepted the medals for himself and Dr. Leary and expressed his appreciation to the city of Providence and to the Rhode Island Medical Society.

Dr. Ruggles relinquished the chair to Dr. Philip Batchelder, President of the Providence Medical Association.

Dr. Batchelder announced that the reading of the minutes of the previous meeting of the Providence Medical Association would be omitted.

Dr. Daniel V. Troppoli, Secretary, read a communication from the Rhode Island Tuberculosis Association announcing scholarships for postgraduate study.

Dr. Batchelder reported that the committee of Dr. Edward A. McLaughlin and Dr. Michael J. O'Connor had filed with the secretary the Association's tribute to the late Dr. George V. Coleman and that a copy of this tribute would be sent to Dr. Coleman's family.

continued on next page



PHILOMEN P. CIARLA, M.D.
President, 1948
NEWPORT COUNTY MEDICAL SOCIETY

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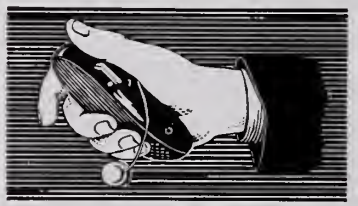
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PROVIDENCE MEDICAL ASSOCIATION

concluded from preceding page

Dr. Batchelder introduced as the first speaker of the evening Dr. James M. Faulkner, Dean, School of Medicine, Boston University, who spoke on the subject, "The Position of the General Practitioner Today."

The most pressing problem facing the medical profession today is the position of the general practitioner. An objective and open minded discussion will help clarify the situation. The status of the general practitioner has changed since pre-World War I days, and the rise of the specialty boards has produced uneasiness among them.

The general practitioner has seen rank and pay in the armed forces made dependent on board artification and also, appointments to hospital staffs made on the same basis. He feels he is losing his prestige.

A general increase in the standard of living has made possible a shift to the specialist and has lost the general practitioner a portion of his practice. There has been a trend of shifting to hospitals for deliveries and in other fields as well. The Blue Cross has augmented this. The general trend of making staff appointments dependent on board memberships has lost the general practitioner his staff appointment. Too often hospitals have used board requirements conveniently in staff appointments. What is the outlook of the general practitioner for the future?

The general practitioner will continue to carry out the bulk of medical practice. He plays an essential role in the medical profession. He, better than the specialist, can understand the patient as a social human being. There will always be a demand and need for the family physician. What is being done to affect the situation.

Practically all teaching in medical schools is done by specialists. Medical schools could assist by developing in hospitals internships directed for general practitioners. Some teach courses in district medicine in which students make house calls.

A one-year rotating internship is inadequate for general practitioners; it should be at least two years, including one year rotating and the second year devoted to medicine or surgery with second year accepted by a board if intern wants to carry on. Students judge hospitals on the basis of their teaching programs.

Some hospitals have rescinded the rules requiring board artification. Some have added general practitioner sections.

A Specialty board in general practice would not help — it would still leave a vast majority, about 90 per cent, that would not have the requirements. The Board of Internal Medicine has helped by lowering its requirements. Four years of general

continued on page 198

recent definitive findings on

Benzedrine Sulfate

in the treatment of overweight

A conclusive study* on the action of amphetamine in weight reduction brings out four significant points:

1. With BENZEDRINE SULFATE "the obese subjects lost weight when placed on a diet which allowed them to eat all they wanted three times a day . . ." Later, these same overweight subjects continued to lose weight when allowed to eat—if they so desired—before retiring.

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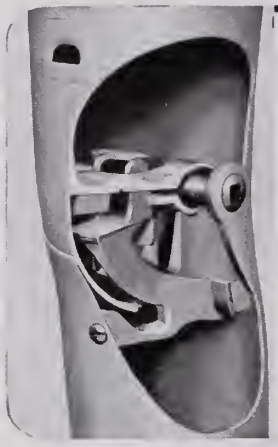
*Harris, S.C.; Ivy, A.C., and Searle, L.M.: The Mechanism of Amphetamine-Induced Loss of Weight: *A Consideration of the Theory of Hunger and Appetite*, J.A.M.A. *134*:1468 (Aug. 23) 1947.

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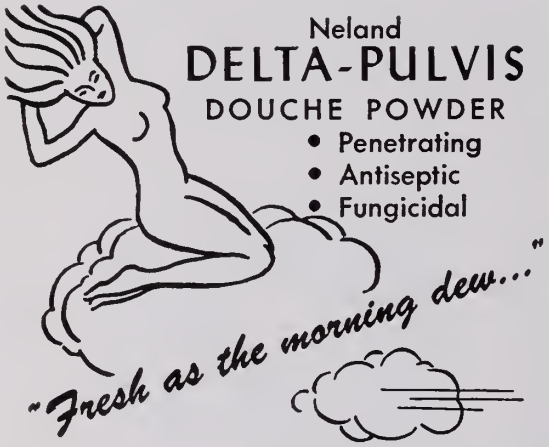
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The knee-joint cross-section shows that Hanger Artificial Limbs are not complicated mechanisms, not loosely-fitted pieces, but a few expertly-machined parts carefully assembled by experts. The simple construction making possible the efficient operation of Hanger Limbs is the result of long study and research. It is dependent on precision-made parts properly assembled. Hanger craftsmen are carefully selected and trained for this important work. Each Hanger Limb therefore conforms to specifications developed by years of experience.

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PROVIDENCE MEDICAL ASSOCIATION

concluded from page 196

practice equals one year of residency in board requirements.

Comments on the discussion were by Doctors Halsey DeWolf and Samuel D. Clark.

Dr. Batchelder relinquished the chair to Dr. Arthur H. Ruggles, President of the Rhode Island Medical Society, who introduced the second speaker of the evening, Mr. Oliver G. Pratt, Superintendent, Rhode Island Hospital, who spoke on the subject, "Graduate Medical Education in Relation to Hospital Economics."

Hospitals not only furnish facilities to the surgeon and medical man to give patients the best medical care, but also train young doctors and nurses to serve the community.

The administrator and its medical staff must work under the Trustees who give time and leadership so essential to the hospital.

Hospital rates on the whole have climbed less high than personal incomes. Because of the high income tax, hospitals do not receive large endowments as they once did.

An internship is a form of apprenticeship. An intern receives training for performing tasks at the hospital. A hospital requires supervision of its educational facilities. Seventy per cent of interns are trained in voluntary non-profit hospitals and therefore, hospital cost must include the cost for education of the interns. There are more internships than available interns so now there is competition in getting good interns.

The medical students judge hospitals by their education programs which is an important adjunct to intern training. The Rhode Island Hospital graduates twelve residents a year. This is one-half the required number according to population. Should the patient pay the cost of intern and resident training? The patient who participates receives better care. Without education, hospitals cannot progress. The best service a hospital can give to a community is to provide well trained future physicians for the community.

Dr. John F. Kenney of Pawtucket discussed Mr. Pratt's paper from the medical viewpoint. He laid particular stress on the difficulty smaller hospitals have in getting a quota of interns. He made it clear that unless the medical profession changed their requirements to make this possible the government would step in and assign them.

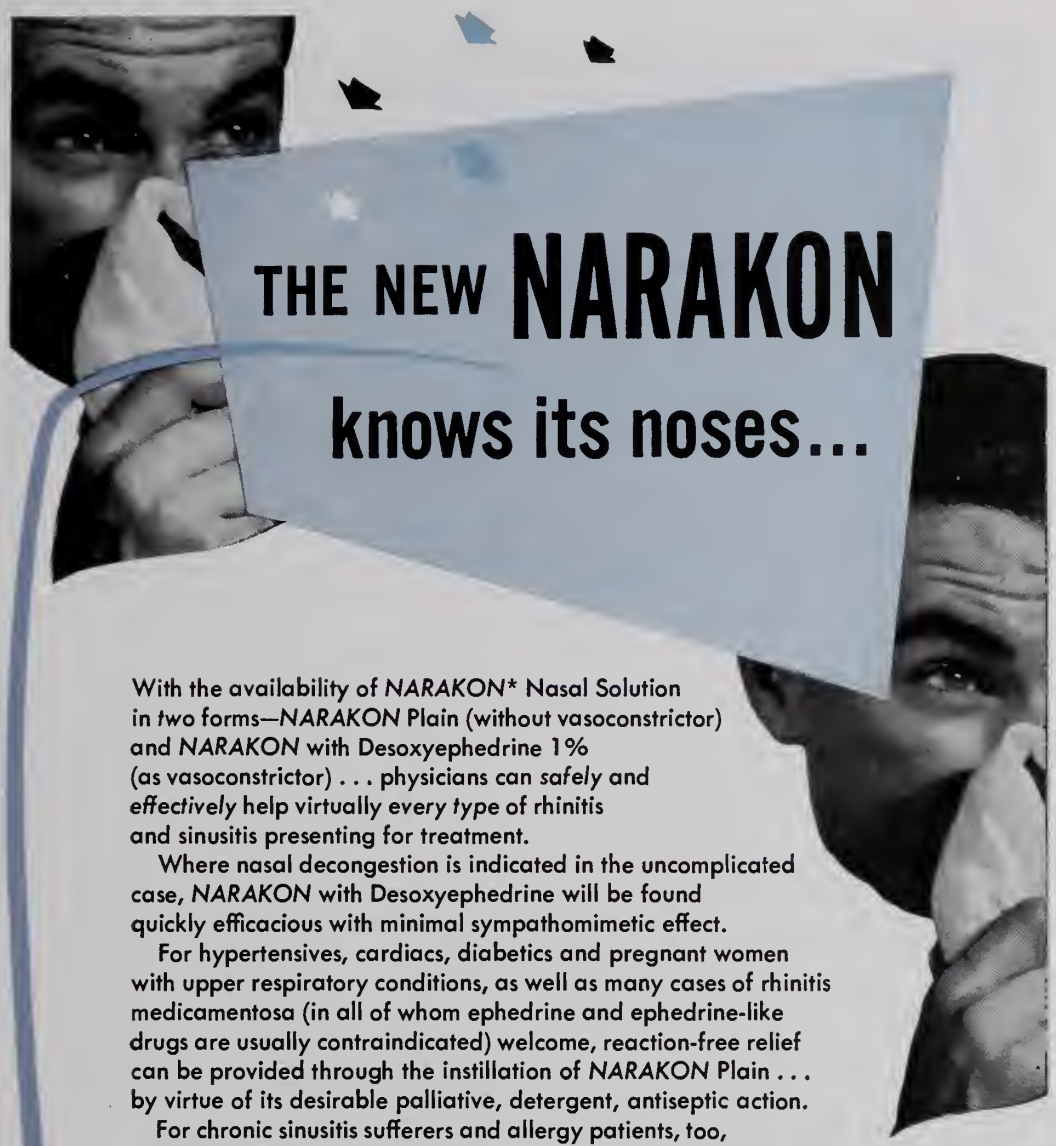
There was discussion from the floor by Doctors Alex Burgess, Anthony Corvese, and Rocco Abbate.

The meeting adjourned at 11:05 p.m.

Attendance 167. Collation was served.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D.
Secretary



THE NEW NARAKON knows its noses...

With the availability of *NARAKON** Nasal Solution in *two* forms—*NARAKON* Plain (without vasoconstrictor) and *NARAKON* with Desoxyephedrine 1% (as vasoconstrictor) . . . physicians can *safely* and *effectively* help virtually *every type* of rhinitis and sinusitis presenting for treatment.

Where nasal decongestion is indicated in the uncomplicated case, *NARAKON* with Desoxyephedrine will be found quickly efficacious with minimal sympathomimetic effect.

For hypertensives, cardiacs, diabetics and pregnant women with upper respiratory conditions, as well as many cases of rhinitis medicamentosa (in all of whom ephedrine and ephedrine-like drugs are usually contraindicated) welcome, reaction-free relief can be provided through the instillation of *NARAKON* Plain . . . by virtue of its desirable palliative, detergent, antiseptic action.

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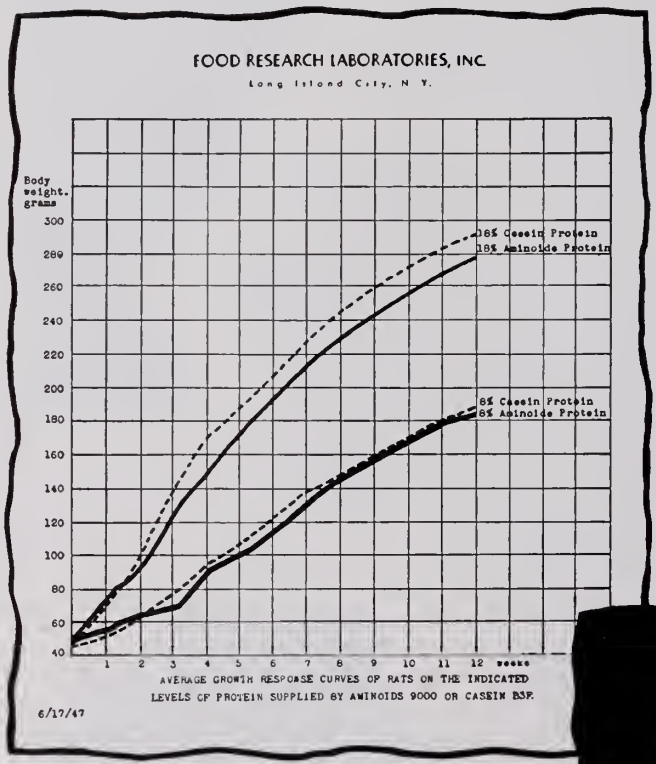
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INTERN TRAINING IN THE HOSPITAL SYSTEM*

CHARLES F. WILKINSON, JR., M.D.

The Author. *Charles F. Wilkinson,* M.D., *of Ann Arbor, Michigan. Assistant Professor of Internal Medicine and Coordinator of Graduate Medical Education, University of Michigan, Ann Arbor.*

IT IS DIFFICULT for me to speak on intern training without considering at the same time training of the resident and the continued training of the practicing physician. I shall, therefore, try to outline certain broad principles that have to do with medical education rather than confining myself to the training of the interns specifically. No longer is it possible to graduate a man from medical school with sufficient knowledge to last him for 30 years, which is about the expected active life of the "lucky" doctors. It is the responsibility of medical schools and hospitals to offer training for the recent graduate of medical schools and to offer opportunities for continuing their education when they enter the private practice of medicine. Let us consider the three ordinary types of internship and then proceed through the logical development of assistant resident, resident, and finally, practicing physician.

The three usual types of internships as offered in America are:

(1) The straight internship in which the intern will devote his entire time for a year or more to one service. This is more common in the East than in other parts of the country.

(2) Some states require that an individual have a "rotating" internship, which means that the intern will spend a varying amount of time on each service in the hospital. This is the usual internship and is what is commonly understood when the term is used unmodified.

(3) Many people feel that a year is too short a time for an intern to adequately cover all services in a hospital, and a combination between the straight and rotating internship is becoming more and more common and is called the "mixed" type of internship. In this type of internship the intern will spend approximately 6 months on one service, and the remainder of his year in closely allied services.

I feel that there is a definite place for all 3 types of internship, but also feel that the rotating internship, if to be best exploited, should probably be for a term of 2 years. The training of the intern in any type of service should be the same in principle. He should be expected to work up cases admitted to his service under the supervision of the assistant resident. He should be prepared to present these cases to the resident or the visiting physician, and it is my feeling that a certain amount of laboratory work is a great teaching aid. I am not in favor of rotating an intern through a laboratory service where he does blood counts and urine analyses from morning until night. I do feel, though, that at his stage of development he should do a blood count and urine analysis on each case that he works up. This presents a difficulty in certain hospitals where surgical patients are admitted in large numbers and late at night and operated early the next morning. The only answer I have to this type of internship is that the intern is being exploited and the hospital and the hospital staff are shirking their duty to the intern.

The intern should no longer be considered a slave. This is considered as well put, for in many institutions he is considered as cheap labor and no responsibility is felt towards him, either for salary that would supply the barest elementary comforts, or for any type of teaching program. In my opinion, these institutions are not training interns and should hire more orderlies and small boys to do their errands, and technicians to do their lab work.

Obligation of the Hospital

Before I can go farther in the duties of the intern, I feel it is necessary to speak of the obligation of the hospital to the intern. He is a Doctor; has spent from 7 to 9 years in acquiring his medical education and is trying to continue to improve it. That is the only reason that he is in the hospital. He is willing to make many sacrifices for good training, as evidenced by many excellent training institutions that pay no salary other than room and board. I do not mention this practice to justify it, but to illustrate how eager the average intern is to obtain a good teaching internship.

The intern should be given time for study and a pleasant place in which to study. The hospital

continued on next page

* Presented at the Third New England Institute for Hospital Administrators, at Brown University, Providence, on June 25, 1947.

libraries should be well stocked with journals and basic text and reference books, and he must not be so tired by the time he gets to the library that he will fall asleep while reading. He should be paid a salary that will at least enable him to obtain some recreation and provide him with bare essentials. I am fortunate in that I only have to recommend that these things be accomplished, and do not have to work out the budget with which they are accomplished. The intern, as I mentioned, should be closely supervised by the assistant resident and by the visiting staff. Each procedure, whether for diagnostic or therapeutic purposes, should be explained to him, even though they appear self-evident to the experienced practitioner.

Minimum Requirements for Teaching Conferences

Certain definite conferences must be arranged for him and he must be given time to attend. I would consider the following as the minimum requirement for teaching conferences:

(1) An X-ray conference where cases are presented and discussed as to why X-rays were necessary. Then discussion by the roentgenologist both from the diagnostic point of view and also from the point of view of the necessity for a given X-ray procedure. In this way the intern will see X-rays on patients he is familiar with and will also have valuable criticism from the X-ray department as to the specific procedure ordered. He will see the need for varying the type of X-ray and on frequently consulting the roentgenologist before they are ordered. He will learn to save the patient unnecessary cost incurred by needless X-rays and will learn a great deal about interpretation of films. A conference such as this should be held once each week in a teaching hospital.

(2) Clinical pathological conferences should be held weekly and should be so conducted that both the resident staff and the attending staff are frequently "put on the spot" as this is one of the most stimulating types of medical instruction.

(3) Clinical conferences should also be held weekly, and the cases presented by the intern. The pertinent literature should be presented by the assistant resident, or resident, followed by general discussion by the visiting staff. It is better, I feel, to make these conferences of one hour in length and to present only one or two cases and have them well worked up rather than having longer conferences or trying to present a large number of cases during an hour.

(4) A Journal Club should be organized and run by and for the intern and resident staff under the supervision of an educational committee or preceptor.

(5) It would seem unnecessary to point out the value of the intern attending autopsies on cases which he has worked up, and if possible, as many others as he has time. The administrative staff should not take a negative or complacent attitude toward autopsies, but should make it as easy as possible for the intern and resident staff to obtain them and be present. Frequently the visiting staff feel that it is not necessary for them to attend autopsies. In effect, this tends to diminish the value of the autopsy in the eye of the resident staff, for he feels that if it were really important, the attending man would be present.

(6) During the year, certain selected topics should be presented to the intern in the form of lectures. These could be at night and need not interfere with his routine house duties. It would seem to me better if these lectures were relatively infrequent and given by an individual particularly well qualified rather than frequent lectures by persons who were chosen for their availability rather than their command of the subject. During his intern year, he will probably not have time to attend many medical meetings outside of his hospital, but if this is practicable, he should be encouraged to go.

(7) Last, and by no means least, is the teaching ward rounds which I touched on when I spoke of the relation of the intern to the visiting and resident staff. If the number of visiting men on the service is large, it would seem best to assign them in rotation to conducted teaching rounds for the entire intern and resident staff of that service. In many hospitals, this is done on the private patients of other physicians. If the ward rounds are conducted so that it is evident that they are being made for the instruction of the intern and resident staff, I do not believe any difficulties will arise in one private physician using another private physician's patients.

The Assistant Residencyship

The second stage in the medical graduate's educational development, if he intends to specialize, is the so-called assistant residency. Here, he is given more responsibilities and in turn assumes the role of buffer for the physician as well as the administrative staff of the hospital. He supervises the intern and it is his responsibility to see that the intern carries out his duties promptly and carefully. The assistant resident should write an admission note on each patient as soon as he is admitted; he should inform the visiting physician that the patient has been admitted and inquire as to the orders that the visiting physician wishes. If the hospital has a large ward service where patients are admitted without their own private physician,

continued on page 204

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INTERN TRAINING IN THE HOSPITAL SYSTEM

continued from page 202

then he should turn to the resident who would then notify the attending man, if need be. The assistant resident should be the link between the patient's family and the private physician. He can save the attending physician many worries by assuming this responsibility and can create much good will for the hospital by thoughtful and courteous treatment of the patient's family.

The conferences that were mentioned above should, of course, be available to the assistant resident, and in addition, he should frequently present the recent and pertinent literature at staff meetings so that he may be able to learn the art of public speaking. In large cities, or in hospitals with university connections, a person gifted in public speaking might be asked to address the resident staff and give them some helpful hints, and even correct their faults.

Again, I must stress the necessity of having facilities available for the assistant resident to study, and time allotted for this. It is an ideal time for him to start in some research problem with an older member of the staff; preferably one that he can continue for the next year or two during his training.

Responsibilities of the Resident

The last step in our Doctor's formal educational development is that of the resident. Here, he should have broad responsibilities; be more or less on his own in the Out-Patient Department; act as house consultant for the other resident staffs in the hospital. If he is to be a surgeon he must be given responsibility for certain operative procedures. This, of course, should be closely supervised by an attending physician, but at the same time he should be allowed to do the actual work. If the hospital is connected with the university, he should be employed in the teaching of students and of course in the teaching of interns and assistant residents, whether there are university connections or not. He should be valuable in the teaching program of the nursing school in the hospital and should be given some time to continue the research problem he started the year previous.

I have said nothing so far regarding the basic science training of the intern and the assistant resident. With the requirements of the various specialty boards, this is presenting more and more of a problem. In a university hospital, basic science faculties are available from the medical school, and basic science continuation training may be carried out all through the intern and the resident training period. In a large university hospital, there are usually available individuals who are engaged in fundamental research which is frequently more of a basic science nature than clin-

ical. These people are invaluable in teaching the intern and residents. The problem is quite different in the voluntary hospital that has no university connection. We have attempted to solve this problem in Michigan by affiliating with hospitals throughout the state and aiding them in their resident training programs. We have set up certain basic minimum teaching requirements for these hospitals which are essentially the ones I have described above, and during one year of the resident's training period, we bring him to Ann Arbor where special basic science courses are offered to him. He is in attendance at the University of Michigan Medical School his third year away from medical school. Here his mornings are spent in courses specifically developed for him. He is with a group of other residents. He is not given "rehashes" from sophomore lectures nor is he presented with courses primarily developed for graduate students in the basic sciences, but given courses specifically designed for him. This is one solution to the problem of presenting continuation study in the basic sciences to the resident. There are many others, and a program that seems to fit well in one section of the country is not necessarily designed for another.

In addition to the responsibility for the man during his year at the University, the medical school assumes the responsibility of sending visitors from our staff to the affiliated hospitals to conduct clinics and act as consultants, if desired.

During the resident's last year, he should attend at least one scientific meeting of major importance and if necessary, the hospital should subsidize him to the extent necessary in attending this meeting. More meetings, of course, would be desirable but are frequently not practicable.

What of the General Practitioner?

I have so far dwelt on the training of the intern and resident who is presumably training for a specialty. What of the general practitioner? Is there a need for this type of doctor anymore? Opinions on this point differ widely. It is my belief, and the belief of a large number of the faculty of the University of Michigan Medical School, that it is our obligation to encourage medical graduates to go into general practice. Michigan is largely a rural state, particularly in the northern part of the lower peninsula and in the upper peninsula. It seems to many of us that although group practice may be considered ideal, it will be some years before the rural areas in Michigan can be effectively served by such practice, if they ever can be. We feel that the best answer at present to our problem of furnishing medical care to the rural population is the well-trained general practitioner.

continued on next page



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1. Kasper, J. A. and Jeffrey, 1. A.: A Simplified Benedict Test for Glycosuria, Amer. J. Clin. Pathology, *14*:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, J. Amer. Med. Tech., *8*:606-14 (Sept.) 1947.

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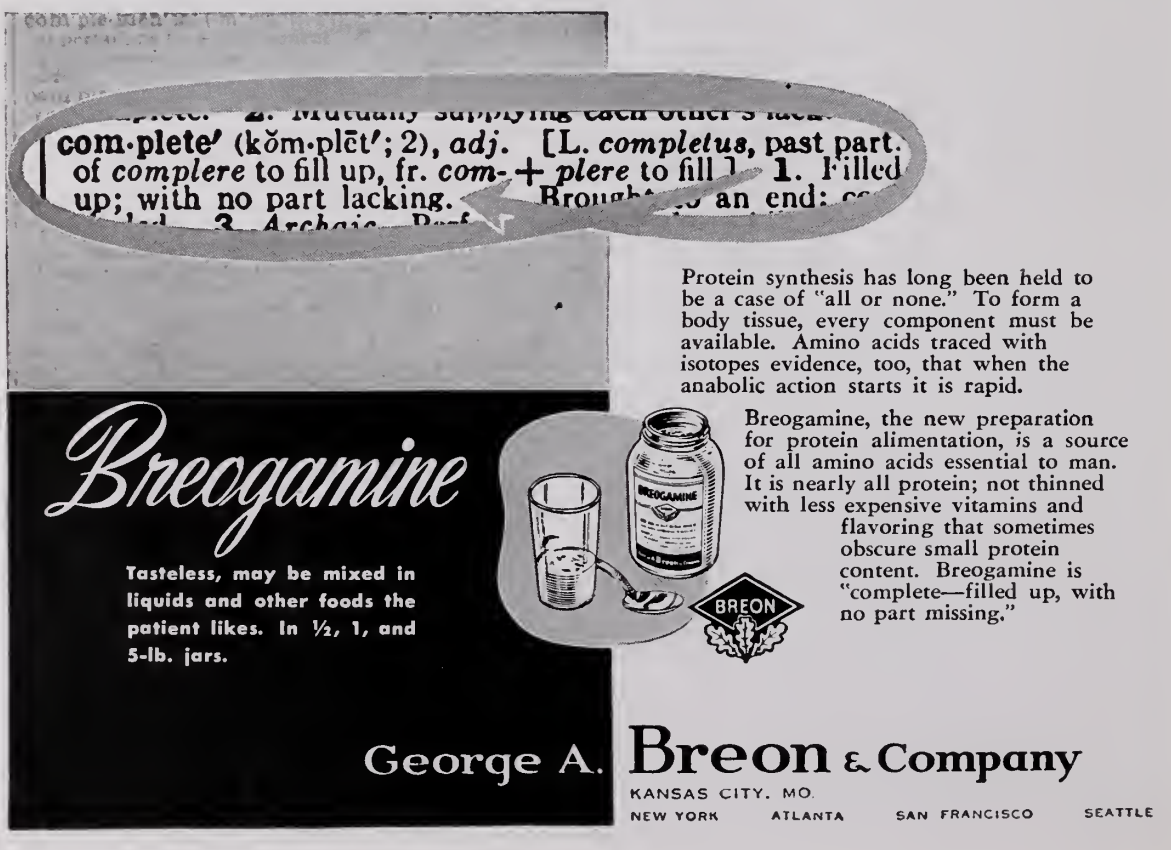
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We have embarked on a program whereby we affiliate with certain hospitals throughout the state in a 2-year general residency program, specifically for the training of the man who desires to go into general practice. All that I have said before in regard to intern and resident training for the specialist, is equally important in the training of the general practitioner. Our standards for affiliation in the 2-year program are no less high than affiliation for specialty training. The only difference is in the end desired. We insist that training programs of high calibre be inaugurated and as much thought be devoted to them as in the training of the specialist.

I have said much this morning regarding the obligations of the hospital and have dwelt very little on the obligations of the intern and resident to the hospital. My opinion is that when a hospital conducts a good training program it is more than repaid by the type of service given in return by its resident and intern staff. Its patients receive the best medical care possible, and it is fulfilling one of its prime purposes—the training of young doctors, and acting as a medical center for the continuing education of the practicing physician in its community. In this way it will raise the standards, not only of medicine locally, but will continue to the constant elevation of medical standards throughout the country.

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INTERIM SESSION OF THE A M A

Report of the Delegate from Rhode Island

HERMAN A. LAWSON, M.D.

THE FIRST INTERIM SESSION of the American Medical Association was held in Cleveland. The House of Delegates met on January 5 and 6. The official details of the business transacted will be published in full in the AMA Journal so that I shall not attempt to give a complete report of all matters discussed. The General Practitioner's Award was bestowed upon Dr. Archie C. Sudan of Kremmling, Colorado.

After a report by the Chairman of the Board of Trustees regarding increased expenses and activities of the national Association, it was clear that the income of the Association must be increased during the coming year. It was therefore voted by the House of Delegates that the annual dues for 1948 shall be $12.00 and that the annual dues be set by the Board of Trustees thereafter, but not to exceed $12.00 per annum.

A resolution was introduced recommending that the Council on Medical Education and Hospitals refuse approval for the training of residents and interns to those hospitals guilty of exploitation of the practice of medicine. It was pointed out that such specialties as pathology, anesthesia, radiology, and physiotherapy constitute the practice of medicine and that there is a tendency on the part of certain hospital administrators to utilize the profits resulting from the operation of these departments in their institutions. Although the House of Delegates disapproves of such practices, it was pointed out that action as proposed by the resolution would probably result in legal action such as has been brought against the AMA previously and the resolution was therefore disapproved.

A report of the organization and meeting of the World Medical Association in Paris in 1947 was submitted. One hundred and twenty-five Delegates from 45 nations attended. There were four Delegates from the U. S. The General Assembly of this World Association will be made up of two Delegates from each National Medical Association. Germany was not admitted and the Medical Association of Germany must repudiate war crimes committed by its members and expel those responsible before becoming members of this World Association. The meeting in 1948 will be held in Czechoslovakia. The Delegates from the American Medical Association agreed to raise $50,000 per year for five years by voluntary subscription to aid in the organization, with the provision that the headquarters of the General Secretariat must be in North America. New York City has been selected and the headquarters will be open about the first of March of this year. The General Secretary has not yet been selected. There are to be three assistant secretaries, one English speaking, one French speaking, and one Spanish speaking. It was felt by all those who are interested in the development of this new World Medical Association that it will be of great value in promoting a better understanding between physicians in all countries in the world and an effective force to help maintain world peace.

The President of the American Medical Association, Dr. Bortz, spoke. In his talk he emphasized the tremendous new problems, which this atomic age will produce. Products of atomic energy will be used more and more in industry and there is urgent need for greater understanding by physicians of the hazards involved and the means of protection. He feels that organized medicine must prepare plans for emergencies which may arise from the use of radio-active substances in industry as well as war. He stated that the unprecedented derangements of life that would result from an atomic explosion present a challenge to American medicine, and that doctors, hospitals, and nurses are as a whole not prepared to deal effectively with large-scale disasters. He urged that each state society concern itself with this problem to speed development of essential plans to cope with disasters which we may face in the future.

The Committee to study with the Nursing Problem reported that the serious shortage of nurses is a problem which has not been solved. The committee recommended training of more practical nurses and attendants; that nurses not be assigned improper duties. There was general agreement that more nurses of a lower grade than the present highly trained professional nurses must be trained. They suggested that, in order to attract more young women into the field of nursing, one must provide social security and retirement plans for them. A permanent Conference Committee of five members each from the American Medical Association, American Nurses Association and

continued on page 210

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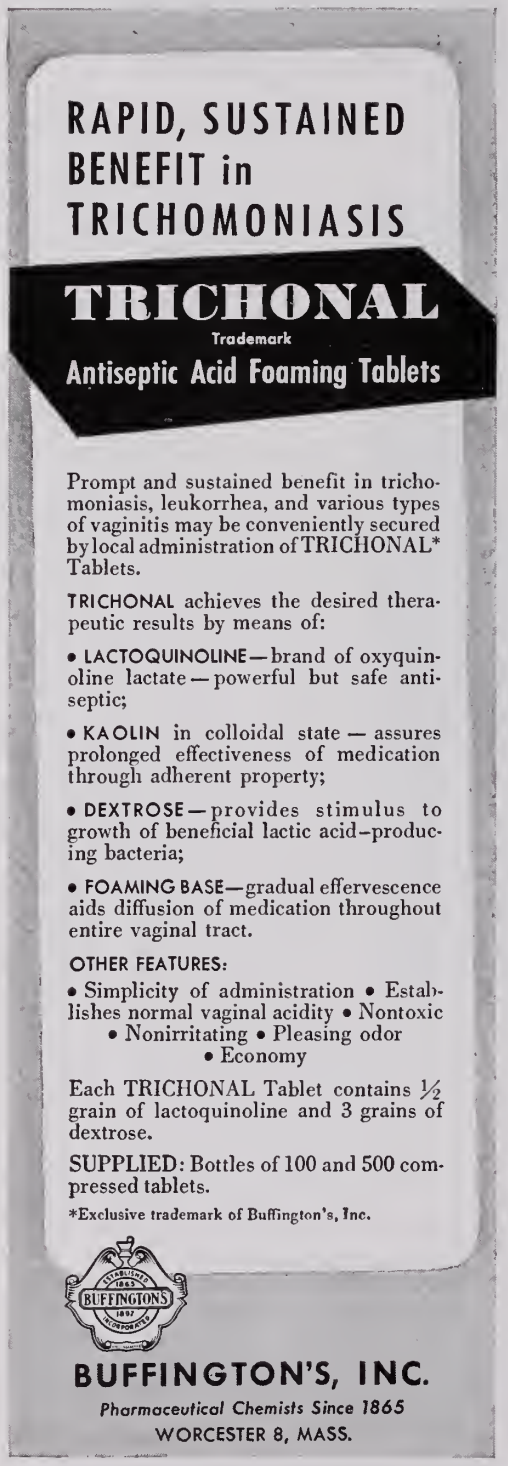
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INTERIM SESSION OF AMA

concluded from page 208

American Hospital Association will continue the study of this urgent problem.

There was discussion of a proposal to limit the number of interns for each hospital depending on its bed capacity to insure more equitable distribution of interns throughout the hospitals of the United Staes. This problem will be studied by a committee that will report at the annual meeting in June.

A proposal to limit the tenure of office of the members of the House of Delegates was defeated since it was very properly considered that tenure of office is a decision to be made by the State Societies who choose the Delegates to the national Association.

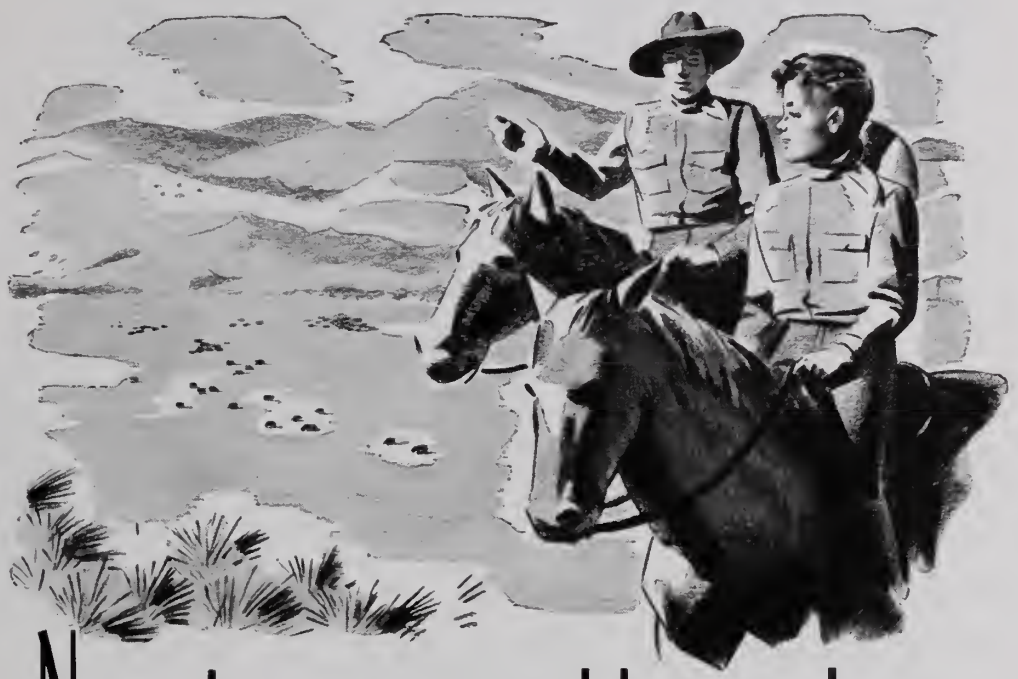
A resolution was approved which will call attention of Congress to the improper use of Federal Funds for propaganda in the Armed Forces.

The increased danger of the introduction of contagious diseases of all types into the United States by immigrants from so many parts of the world where public health service and medical care has been seriously disrupted by the war was stressed in one resolution introduced. This resolution recommended that thorough physical examinations including x-ray of the chest be done on all immigrants at the country of origin, or if this is not possible, at the port of entry in the United States. It was voted to call this to the attention of the U. S. Public Health Service, the Immigration Service and all others concerned.

Rather than presenting a routine report of the official business of the AMA, all of which has been thoroughly and accurately reported in the AMA Journal, I should like to pass on to the members of the Rhode Island Medical Society what was my most important reaction as a newcomer attending for the first time a session of the House of Delegates.

I had a firm conviction as a result of observation of the activities of the Delegates that the affairs of the American Medical Association are in good hands! It was enlightening and encouraging to see the serious and earnest manner in which the Delegates participated. Many are outstanding men who are leaders in American medicine and represent the best in American medicine. Many have obviously devoted much time and effort in performing the duties which have been assigned to them. The discussions even when there were marked differences of opinion, were conducted with courtesy and on a high plane.

So far as I am concerned, my experience at this meeting refutes completely the contention of those who would have us believe that the AMA is not democratic and that it does not truly represent the opinion and wishes of the majority of its members.



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BOOK REVIEWS

SEXUAL BEHAVIOR IN THE HUMAN MALE, by Alfred C. Kinsey, Professor of Zoology, Indiana University; Wardell B. Pomeroy, Research Associate, Indiana University; Cylde E. Martin, Research Associate, Indiana University. *W. B. Saunders Company, Publishers, Philadelphia and London*, 1948

This remarkable book is the first of a series of books which are to appear as a result of a scientific research and study on problems in human sexuality. The survey was conducted by a staff of scientists at Indiana University and sponsored by the Committee for Research on Problems of Sex by the Medical Division of the Rockefeller Foundation.

Matters pertaining to sex have always held the interest and curiosity of mankind. The number of publications on sex will probably surpass any amount of literature written on any other subject. However, most of this material was not based on any factual findings, but reflected merely the writers' personal experiences, opinions and prejudices. In this manner a great amount of contradictory, untrustworthy, misrepresented and deceptive material has been accumulated. As a result our knowledge of factual human sexuality lacked scientific foundation.

Therefore, the research workers of this survey undertook to work out their problem as an objective scientific study. They have attempted to bring to our knowledge all the information pertaining to sexual activity and its variations as practiced by the human male of this country during our times. Twelve thousand case histories were obtained from men and women of all ages and of all walks of life. Most recent public poll findings methods were used and the findings were checked and rechecked by men especially trained in this field of work. This book is a result of nine years of such study and includes the summary of the findings and conclusions obtained by the leading workers of this survey.

This study is most complete and the wealth of material brought out in this book is astonishing. No matter how apparently insignificant or how important some of the subject matter appeared, as long as it concerned sex, the writers have tackled it with equal objective thoroughness. There is an enormous amount of factual data pertaining to medical, psychological, sociological, physiological and pathological aspects of human sex behavior.

Besides purely factual findings the authors of this book have done their own pioneering in explaining the reasons and aims of their study. This book is provocative enough in its factual findings, however, the authors have added interest by discussing their findings courageously as they affect some of the theories promulgated by various psychiatric schools of thought. Some of these ideas are supported by the findings of this survey. Others were, *e. g.*, Freud's theory on sublimation, found to be entirely without support.

The book is written in a clear and lucid language. There are many graphs, statistical tables and an exhaustive bibliography. Its place is indeed in the library of a physician, jurist, educator, psychologist, social worker and any person interested in human behavior. However, the use of this book should be restricted. It should not be accessible to adolescents and those lacking the necessary scientific background.

SIDNEY S. GOLDSTEIN, M.D.

TEXTBOOK OF CLINICAL NEUROLOGY, By *Israel S. Wechsler*, M.D., Publisher:—W. B. Saunders Company, $8.50, 1947.

This edition has been extensively revised in order to include the recent additions to knowledge in the clinical field of neurology. However, the general plan follows the previous edition (5th). The noticeable progress in neurology made during the past four years is well described.

The one most noticeable omission in a neurological textbook which is described by the author as a "fairly complete repository of as much clinical neurology as can reasonably be gathered together between two covers", is the way the diseases of the nervous system of infancy and childhood are treated. Little or no effort has been made to bring together and to analyze all available information about these conditions. The neurological complications of diseases, not essentially neurological, are not given sufficient emphasis. Neither are the general aspects of these diseases.

continued on page 214

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Such progress in surgery has been hastened by significant developments in four important fields.

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2. Infection-fighting drugs. Peritonitis, once feared as a frequent complication of abdominal surgery, today is uncommon. The use of such agents as the sulfa drugs and penicillin—to treat infection or to guard against it—has almost eliminated many of the infections which formerly constituted the greatest dangers in surgical procedures.

3. Early ambulation. Doctors have found that getting patients out of bed soon after operations not only speeds recovery, but also prevents many of the discomforts formerly suffered. Bowel and urinary functions are quickly restored. Gas pains are usually avoided. It is not unusual nowadays for a patient to be well enough to go home from the hospital in less than ten days after a major operation.

4. Body Nutrition. One of the problems in surgery has been that the condition which makes an operation necessary is usually one which has depleted the patient's nutritional reserves, and therefore lessens his ability to recover promptly from the operation itself.

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BOOK REVIEWS
continued from page 212

The second point of doubtful value of this text is the inclusion of a section devoted to the neuroses. The enormous development of psychiatry in the past ten years makes it impossible to cover in any more than a wholly superficial manner, the various concepts of the emotional disorders and their manifold manifestations. To include material about the neuroses in a neurological text seems to serve no worthwhile purpose.

Of exceptional value, however, is the author's inclusion of a revised chapter on psychometric tests, now entitled "Psychological Diagnosis of personality disorders in organic brain syndromes." It is written in a manner which indicates the author's acceptance of a very recent trend among clinical neurologists today—to accept the idea that psychological methods enter more and more into neurological diagnosis.

As a textbook of neurology, the reviewer feels that it is at least on a par with the most recent publications in the same field. The disease enties are well described and the signs, symptoms, etiology, diagnosis, and treatment, described in terms already familiar to the specialist and easily understood by those having a basic grounding in neuroanatomy. A more detailed basic description of the electroencephalographic findings in the convulsive disorders and the use of this method in localizing cerebral lesions might well have been included.

THOMAS L. GREASON, M.D.

"Internal Medicine in General Practice" by Robert Pratt McCoombs, B.S., M.D., F.A.C.P. Second edition with 122 illustrations. 741 pages. W. B. Saunders Company, Philadelphia and London, 1947. Priced $8.00.

The substance of the previous edition has been completely revised and rearranged, and much new material has been added. The text consists of abstracts or concise condensations of present day knowledge of those diseases considered to be in the field of internal medicine. The author placed special emphasis on those diseases in which errors in diagnosis and therapy commonly occur. Specific information as to diagnostic methods and clinical tests have been incoporated in the text, as well as detailed recommendations for the treatment of each disorder. Sections on psychiatric disorders, diseases of the nervous sytem, and vascular disturbances of the extremities are included in addition to those sections dealing with the diseases and conditions usually considered to be in this field. At the time of the printing of the book, it was remarkably well up to date in therapeutics. The subject of chemotherapy with the sulfonamides, peni-

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cillin and streptomycin forms an important section of the book. Other new therapeutic methods of proved value or of promise have been added. Among these are: lumbodorsal sympathectomy in selected cases of hypertension, the rice diet in hypertension and certain kidney diseases, high protein diets and protein hydrolysates in malnourished states, folic acid in macrocytic anemias and sprue, serum albumin in circulatory failure and nephrotic states, gamma globulins in the prophylaxis and treatment of measles and infectious hepatitis, chloroquine in malaria, para-amino-benzoic acid in rickettsial diseases, penicillin in syphilis and other infectious diseases, thiouracil and propylthiouracil in hyperthyroidism, estrogen therapy and castration in cancer of the prostate, benadryl and pyribenzamine in allergic disorders, cytochrome C in anoxic states, tridione in psychomotor disorders, heparin and dicumarol in vascular emergencies, and so on. The book has great value to the general practitioner, the student of medicine, and the specialist who wishes to quickly refresh his memory with specific knowledge and recommendations in the field of internal medicine.

HERBERT F. HAGER, M.D.

Pharmacology, Therapeutics and Prescription Writing. For Students and Practitioners. By Walter Arthur Bastedo, M.D. W. B. Saunders Co., Philadelphia, 1947. $8.50.

The fifth edition of this useful reference book has been completely rewritten. Doctor Bastedo felt that this was necessary because of the many new drugs and rapid advances in therapeutics.

Some of the new remedies he considers are rutin, BAL, radioactive iodine, thiouracil, folic acid and the coagulants. Method of action, therapeutics, administration, toxicology, contraindications and different preparations are listed for each drug.

HELEN DEJONG

The Years After 50 by Wingate M. Johnson, M.D., Professor of Clinical Medicine and Chief of Private Diagnostic Clinic, Bowman Gray School of Medicine of Wake Forest College. Whittlesey House, New York, 1947, $2.00

Dr. Johnson, also editor of his state journal, has recently been made a Trustee of the American Medical Association, and is greatly interested in the recognition and organization of the general practitioners of the country.

It seems safe to say that few men could have done a better job with this subject. Although the book is written evidently for consumption by the general public, it will make excellent reading for physicians; and although straight-forward and direct, he plays with no hobbies or personal hunches.

Every chapter is headed with quotations taken from little-known writings. Thus, he quotes Cicero, "A Good Old Rebel (Unreconstructed)", and Plato's "Republic." All through his writings there

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Registration may be made ahead of time by writing to Dr. C. G. Grulee, Secretary-Treasurer, American Academy of Pediatrics, 636 Church Street, Evanston, Illinois, enclosing a check for $10.00 or registration may be at the time of the meeting.

BOOK REVIEWS

concluded from preceding page

are frequent references to interesting people like William Osler, Samuel Johnson, and Amos Alonzo Stagg.

He devotes sometimes full chapters and sometimes portions to specific subjects that he thinks are peculiarly applicable to the aged, such as high and low blood pressure, diseases of the heart, dieting, and rheumatism. This book is easy to read. The reviewer feels that he has gotten a great deal of value out of it. We hope that it will be successful.

PETER PINEO CHASE, M.D.

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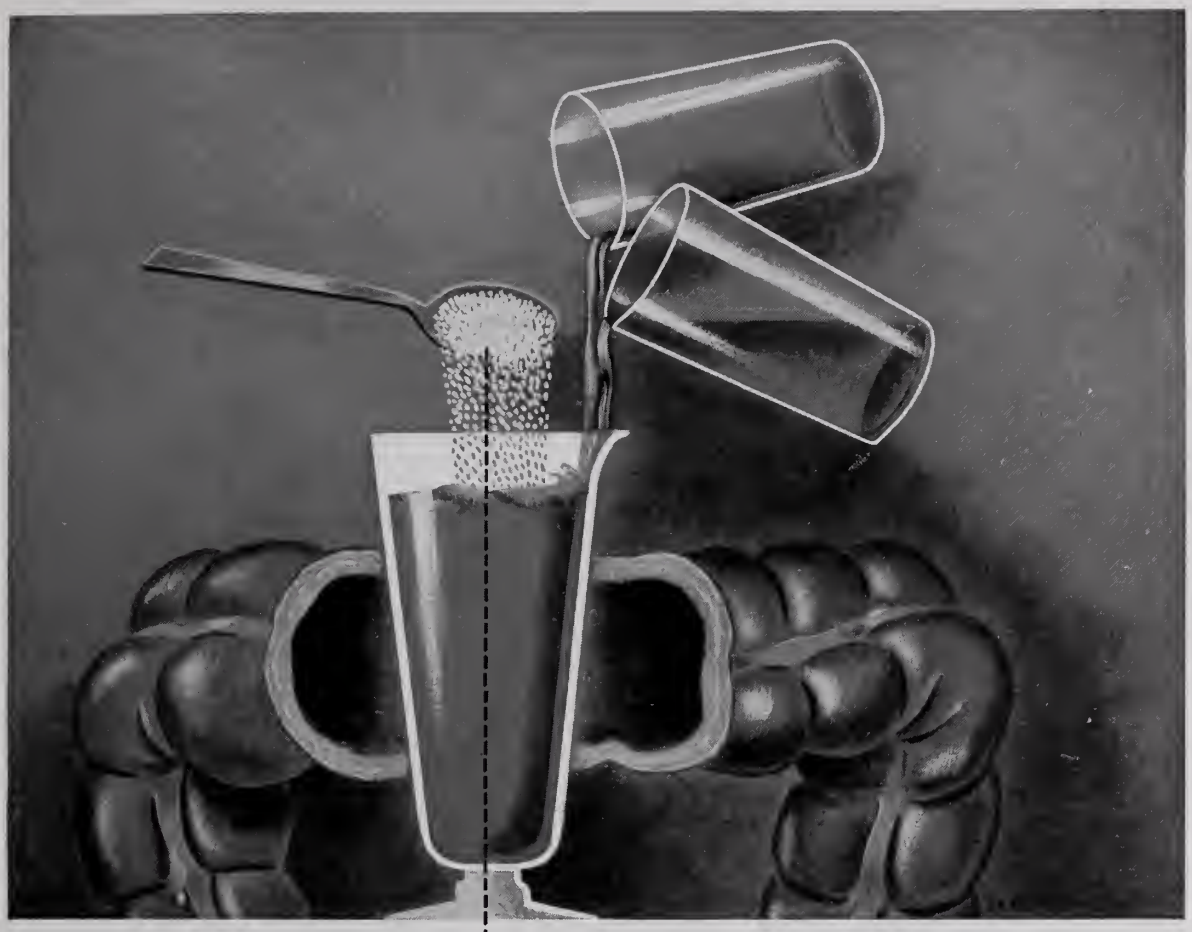


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INDEX OF ADVERTISERS

	PAGE
Abbott Laboratories	162
Alkalol Company	204, 215
American Meat Institute	211
Ames Company, Inc.	205
E. P. Anthony, Inc.	219
Ar-Ex Cosmetics, Inc.	216
Arlington Chemical Company	200
Ayerst, McKenna & Harrison	161
B. & J. Apparatus, Inc.	196
Baybank Pharmaceuticals, Inc.	199
Bayview Convalescent Home	215
Blanding & Blanding	166
J. E. Brennan & Company	182
George A. Breon and Company	206
Joseph Brown Company	182
Buffington's, Inc.	210
Burroughs Wellcome & Co., Inc.	207
Butterfield Drug Stores	182
Camel	209
S. H. Camp Company	163
Ciba Pharmaceutical Products, Inc.	153, 193
Curran and Burton	215
Doho Chemical Corporation	203
Edgewood School	220
J. E. Hanger, Inc.	198
Hillcrest, Inc.	206
H. P. Hood & Sons	160
Langlais Health Institute	215
Eli Lilly & Company	Insert between 166-167
McCaffrey, Inc.	182
S. E. Massengill Company	191
Mead Johnson & Company	Back cover
Medical Milk Commission	216
A. B. Munroe Dairy	214
Mutual Benefit Health and Accident Association	154
Neland Pharmaceutical, Inc.	198
Nutrition Research Laboratories	164-165
Parke, Davis & Co.	213, Inside back cover
Philip Morris & Company	158
Physicians Directory	218, 219
Rexall Drug Company	156
Rhode Island Limb Company	204
Schering Corporation	189
G. D. Searle & Company	187
Sharp & Dohme, Inc.	157
Smith-Holden, Inc.	Inside front cover
Smith, Kline & French Laboratories	197
Spencer Incorporated	190
E. R. Squibb & Son	155
Strand Optical Company	204
Tilden-Thurber	196
The Upjohn Company	194
Winthrop-Stearns, Inc.	217

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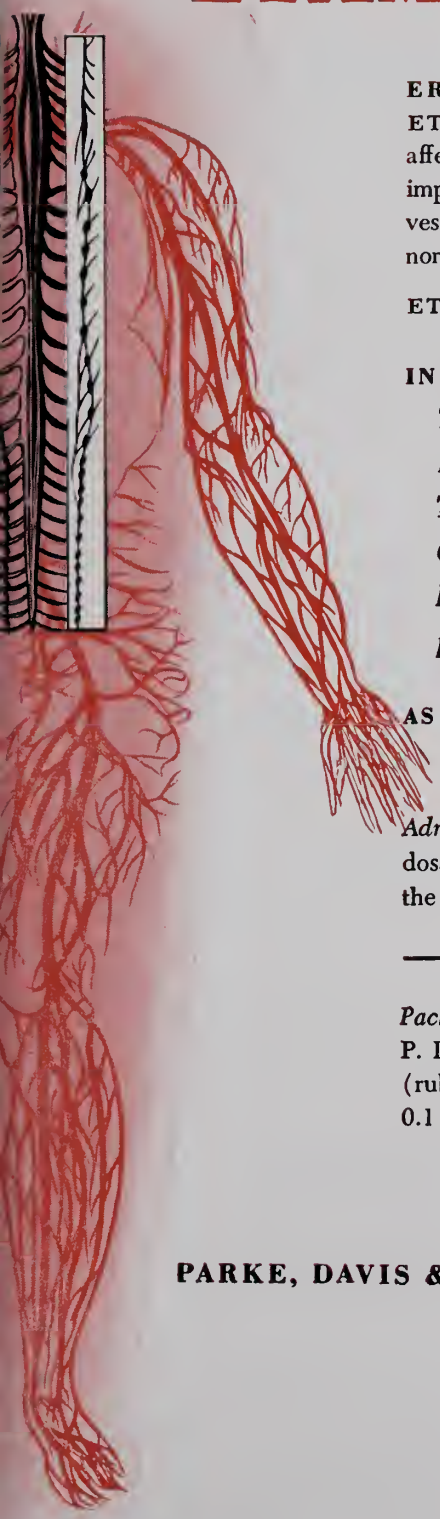
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*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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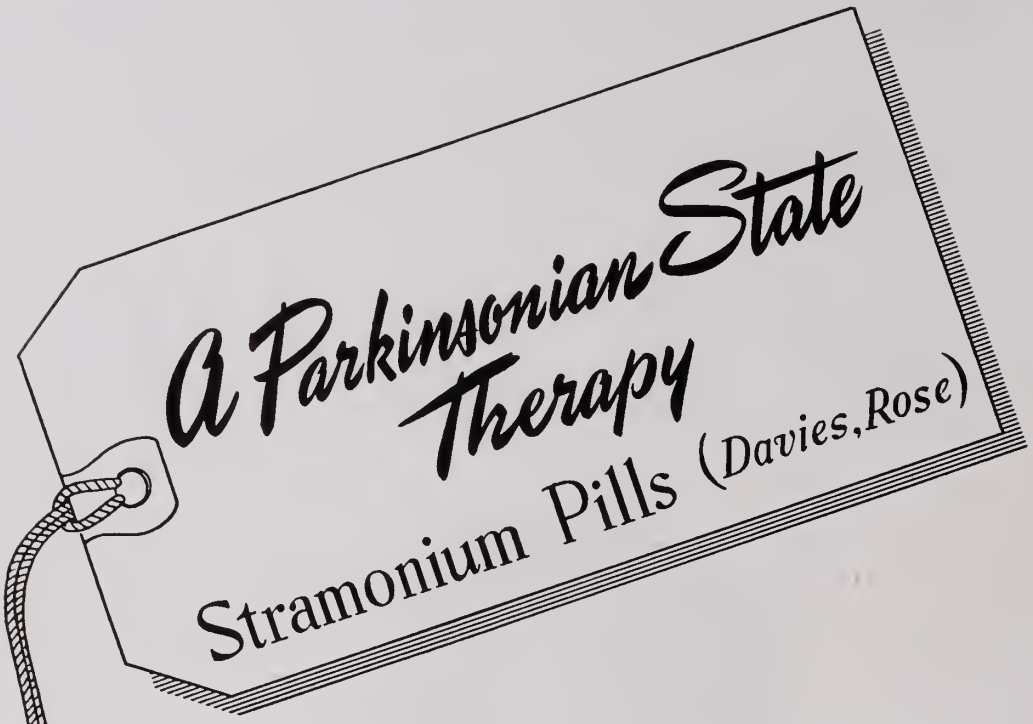
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(See pages 254 - 256 - 258)

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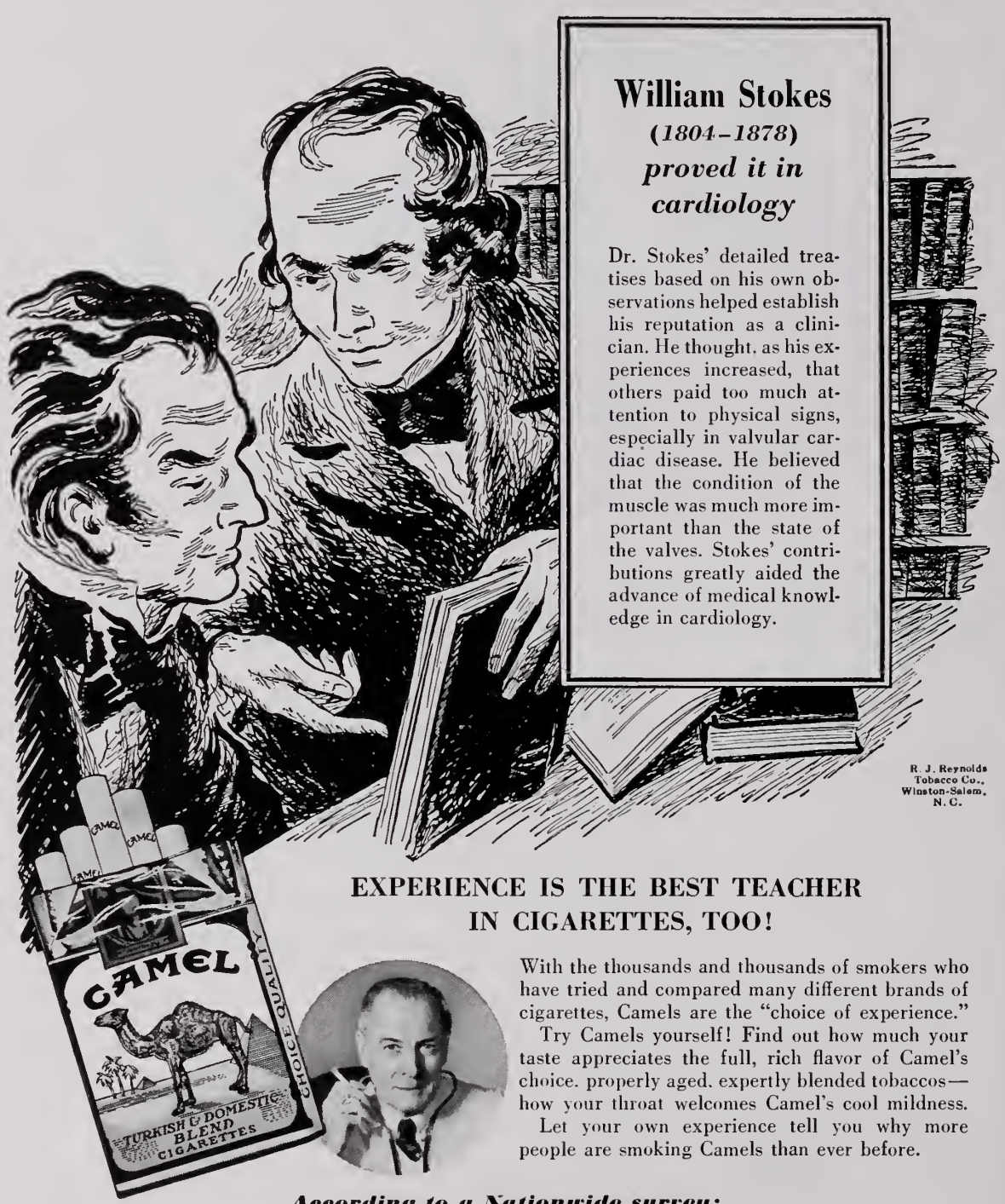
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TABLE OF CONTENTS

PAGE

The Conquest of Puerperal Infection, 1846-1946, *Edward S. Brackett,* M.D. 235
Tuberculosis in Providence, *Peter F. Harrington,* M.D. 240
Symposium on Rheumatic Fever and Heart Disease, *Earl F. Kelly,* M.D., *Banice Feinberg,* M.D., *Francis V. Corrigan,* M.D., *John F. Kenney,* M.D. 243
The Responsibility of The Hospital Administrator to Other Community Health Agencies, *Ira V. Hiscock,* Sc.D. 250
Some Common Misconceptions Regarding Dermatology 272

EDITORIALS

Overtreatment and Gunshot Prescriptions 247
Charles Bradley, M.D. 248
Research 248
Community Leadership 249
Streptomycin in Tuberculosis 249

DEPARTMENTS

District Medical Society Meetings 262
Program of the 137th Annual Meeting, R. I. Medical Society 254
Woman's Auxiliary 270

MISCELLANEOUS

Book Review 275
Exhibitors at the 137th Annual Meeting 275
Index of Advertisers Inside back cover
Wednesday Office Hours 264
Providence Medical Association, Distinguished Service Awards 274
Tufts Alumni of Rhode Island Elect 260
Photographs:
Centennial Exhibits of Providence Medical Association 269
Kent County Memorial Hospital 273



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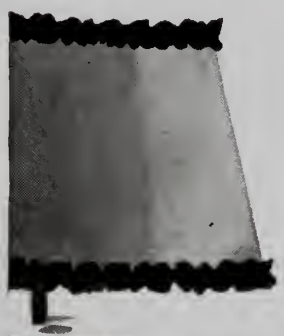
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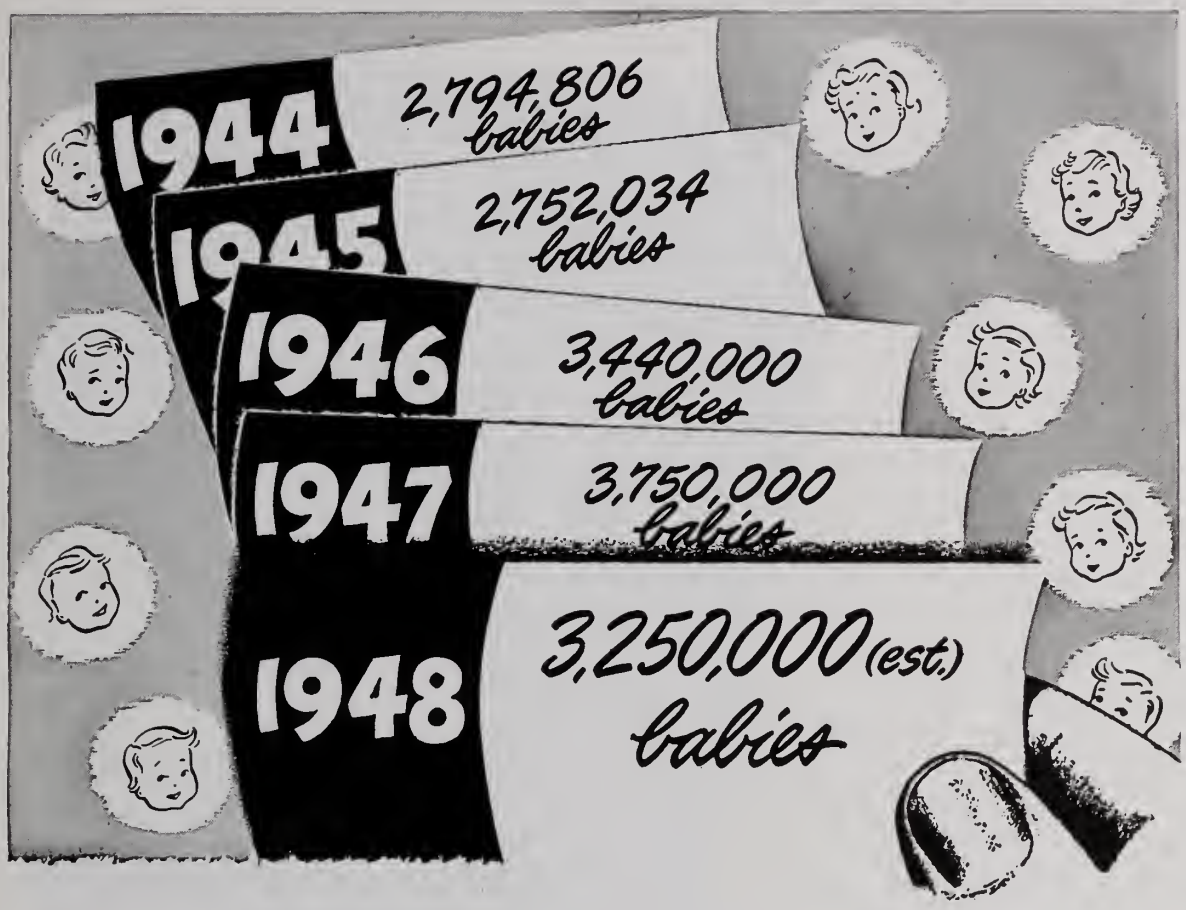
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The RHODE ISLAND MEDICAL JOURNAL

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THE CONQUEST OF PUERPERAL INFECTION 1846–1946

EDWARD S. BRACKETT, M.D.

The Author. *Edward S. Brackett, M.D., of Providence. Former Chief of Staff, Lying In Hospital, Providence.*

MANY OF US may not agree with Henry Ford that history is bunk but he was at least half right. It was Dickens, I think, or was it Mark Twain who said that the trouble with Americans is that "they know so much that ain't so." Medical history, if it does nothing else, shows us how many things that "ain't so" each generation has been sure it knew.

I have used the term Puerperal Infection in the title of this paper rather than Puerperal Fever because the latter term often seems to have been used to mean the epidemic type of infection usually caused by the streptococcus. As used in this paper, the term Puerperal Infection may be defined as a bacterial infection whatever its type in a pregnant or puerperal woman in which the port of entry is in the genital tract. It is not an acceptable pathological diagnosis. It is, clinically, a useful term because it groups together different pathological conditions which have a common etiology and therefor demand common prophylactic measures.

Perhaps we are inclined to exaggerate the prevalence before the modern aseptic era of puerperal fever, at least in its malignant and fatal form. "It is not unknown to such early writers as Hippocrates, Avicenna, Pater, Sylvius and Willis but they made no mention of epidemics nor does it appear that they were seriously impressed with the alarming fatality of the malady". The picture that is apt to flash before our mind's eye when puerperal fever is under discussion is the terrible conditions in, for instance, the Hotel Dieu in Paris in 1778 when seven out of twelve parturients died. Many epidemics are on record in hospitals during the 180 years from 1664 when the earliest reference to epidemic puerperal fever was made by M. Peu of Paris to the mid eighteen forties when real progress began to be made in solving the riddle of the cause of this dread disease and a firm basis was laid for its conquest.

How frequent such epidemics were it would be hard to say but they were frequent enough for Ramsbotham to write: "Some years ago I was solicited to take the medical superintendence of a lying in hospital which it was proposed to establish in the eastern part of London. Though I might have derived no little personal advantage from the connection, I declined the proffered honor; and gave the gentlemen who called on me such reasons for doing so, as induced them immediately to abandon the undertaking; and it has never been revived. Should such an establishment again be formed in any large town, it should consist of a number of small houses detached or at least separated from each other, and no more than one woman should be permitted to occupy any single apartment at a time." Here is the germ of the Cottage Hospital idea at one time so popular and so expensive. The fear of air born infection still persists though we, in Rhode Island, who for years were under the influence of Dr. Charles V. Chapin, take little stock in it.

In answer to those who held that the mortality in hospitals was not much greater than in private practice, LeFort, about 1870, published statistics showing that the mortality among 888,302 hospital deliveries was 1 in 29; of 934,781 home deliveries 1 in 212. Small wonder that the prejudice against hospitals still persisted well into the present century.

Epidemics among the patients of individual doctors were also observed and recorded. When one remembers that until the cause of puerperal fever

continued on next page

was discovered the accoucher would go directly from a case of scarlet fever or from the autopsy room where he had performed a post mortem bare-handed to attend a woman in labor, the marvel is that these epidemics in private practice were not more frequent. The campaign of the medical profession to eliminate the midwife and the confinement of patients in their homes fortunately has been almost completely successful but at the time of which we are for the moment speaking the generally prevalent practice of being attended by midwives in their own homes saved countless women from being the victims of infection carried to them by doctors who were attending cases of erysipelas or scarlet fever or dressing septic wounds. The midwife might and occasionally did carry infection from one obstetrical patient to another but she was not nearly so great a menace as the doctor who was constantly attending septic cases of all kinds.

In this imperfect world there is no such thing as absolute good and an institution that has been useful in one generation and in one set of circumstances in another generation and another set of circumstances may be an obstruction in the road of progress and must be discarded.

What was known and what was believed about puerperal fever a hundred years ago when a clear picture of the cause of puerperal fever began to emerge?

In 1841, Francis H. Ramsbotham, M.D. Fellow of the Royal College of Physicians and lecturer on obstetrics and forensic medicine at the London Hospital published "a new work on Obstetric science" (to quote from the author's preface). In 1845 this work was copyrighted in this country by Lea and Blanchard and in 1851 this house published the sixth American edition. In a letter to the publisher, Hugh L. Hodge, professor of obstetrics in the University of Pennsylvania says:— "this work needs no recommendation from me receiving as it does, the unanimous recommendations of the British periodical press, as the standard work on Midwifery". The first London edition was published in 1841: the fifth London edition in 1867. (He was the J. Whitridge Williams of his day. The first edition of Williams was published in 1903, the last in 1946.)

It is a monumental work, a compendium of the theories and teachings of the practitioners of one hundred years ago. It is upon this work that I have relied to furnish a picture of the contemporary knowledge of puerperal sepsis in the middle of the 19th century when a new phase in the long search for its cause and its prevention was about to begin. The opinions quoted are taken from this work (and occasionally from the Priests of Lucina) and no attempt has been made to distinguish between Ramsbotham's own opinions and those of other writers whom he quotes.

The practitioners of that day were keen observers. No clinical signs or symptoms escaped their notice. They were dependent on the evidence of their five senses almost unaided by the laboratory upon which we moderns have come to lean so heavily but little has been added since their day to their knowledge of symptomology and gross pathology of puerperal fever. While their observations were usually correct their deductions were sometimes of necessity wide of the mark — so wide of the mark that to us they seem ridiculous. They observed that in femoral phlebitis lactation was suppressed and a milky fluid was found in the femoral vein at autopsy. They thought the suppressed milk stagnated in the vein and caused "milk leg". A similar explanation was given for milky fluid found in the peritoneal cavity. In the epidemic in Paris in 1778 at the Hotel Dieu already referred to in which seven out of twelve women delivered died, "milk" was found at autopsy in the abdominal cavities of many patients. Delivery of milk to the hospital was stopped forthwith— needless to say without affect on the mortality rate. How interesting it would be to know which of our present theories will look equally ridiculous a hundred years hence!

As always when beliefs are based on theory rather than on demonstrated facts, there was a great number of opinions as to the cause of puerperal fever. To discuss them at length would be boring and unprofitable but to comment on them, briefly, may be of some interest.

Some of them had no basis in fact. Such are cold; the position of the body in labor; excitement; unstable, excitable nervous habits; despondency; intemperate habits; gas in the intestines; suppression of the lochia; closing of the aperture of the uterine veins; suppression of the milk and its metastasis to the femoral vein or peritoneum; improper and stimulating diet too early. (My own mother whose first child was born in 1870 came out of my wife's room three days after my son was born, her black eyes flashing, her cheeks flushed, evidently very angry. To my question, "What's the matter Mother?", she snapped back, "I've just been in Molly's room. The baby is only three days old. She's having dinner—lamb chops, baked potato, squash and she's going to have ice cream for dessert. When I think how they kept me on slops for three weeks after my babies came I'm so mad I don't know what to say.")

What they held to be primary causes, we today would hold to be in some cases predisposing causes, in others the results rather than the causes; manual removal of placenta; introduction of the hand into

the uterus; injuries; prolonged pressure of the head on the lymph vessels; long labor; the placental wound (first mentioned by William Harvey in 1651); placenta praevia; absorption of putrid matter and pus through the patulous uterine veins. They believed that "some constitutions are peculiarly predisposed to it." (We say that there is lowered resistance to infection and blame it upon a diet deficient in vitamins A and/or B and D.)

Conceding, as many leading obstetricians did, that it was a transmissable disease, they held various theories to explain the mode of its transmission from one patient to another and the port of entry of the contagion into the general system; epidemical constitutional condition of the air (in modern terms, air borne infection); clothing impregnated with the effluvium arising at autopsy from the body of a woman who had died of a contagious puerperal malady. (Bad smells even today are thought to be the cause of sickness. Up to the turn of the century clothing (fomites) was held to transmit yellow fever). The possibility of the examining finger of an obstetrican coming from an autopsy, a case of erysipelas or another case of puerperal fever being the transmitting agent is mentioned but very little stress is laid upon its importance. Many leading obstetricians held the veins at the placental wound to be the port of entry of the contagion.

While any complete understanding of the nature of the disease was impossible before Pasteur made his epoch making discoveries many observers had made deeply penetrating conjectures as to its nature. The analogy between infection caused by "the access of atmospheric air" in amputations and other extensive wounds and infection entering the system through the placental wound was recognized. It was held to be related to scarlet fever, hospital gangrene and erysipelas. As early as 1750 Plouteau called the disease, "epidemic erysipelas of the peritoneum." Ramsbotham had "no doubt that there is a form of fever to which puerperal women are liable, not alone arising from the contagion of erysipelas but in its turn also occasioning that disease in other persons". Ferguson in 1839 stated his belief that "the phenomena of puerperal fever originate in a vitiating of the fluids—and the various forms of puerperal fever depend on the one cause."

There were fumbling attempts at asepsis and antisepsis. Personal cleanliness was insisted on. Changing one's clothes and "performing one's ablutions" after performing an autopsy or attending a patient sick with puerperal fever, erysipelas or scarlet fever was advised but strangely enough no special emphasis was placed on scrubbing the hands. Charles White in 1775 recommended that when the patient had "recovered from fever and was removed into another room, the bedding and curtains be washed, the floor and wood-work cleansed with vinegar, and the room stoved with brimstone, or (with what he believed to be more effectual) the explosion of small quantities of gun powder to drive out the foul air". We may be tempted to smile at these crude antiseptic measures, especially the gunpowder, but I well remember that my own room "was stoved with brimstone" after I had scarlet fever.

If we winnow the wheat from the chaff we find that in 1841 when Ramsbotham's first London edition was published, many outstanding authorities subscribed to one or more of the following theories: that puerperal fever was caused by contagion; that the contagion could be carried from one woman to another by a third person in the clothing, bed linen, etc., and by the examining finger of the attending accoucher; that the contagion entered the body through the placental site; that the contagion of puerperal fever could come from a case of scarlet fever or erysipelas and, per contra, that the contagion of puerperal fever could cause erysipelas; that lesions found at autopsy on men and non-pregnant women were identical with those found at autopsy on women dying of puerperal fever; that the mode of infection was analagous to that of hospital gangrene; that if several successive cases of puerperal fever occurred in the practice of one physician it was due, not to coincidence, an act of God or atmospheric conditions, but by actual transference by the physician of the contagion from one patient to another; that the varied pathological and clinical manifestations of the disease were all due to one cause.

There was, of course, no unanimity of opinion as to what that cause was—or indeed that one cause could account for such seemingly different conditions. The earnest searchers after truth must have felt they were still groping blindly in a black night of incomplete knowledge. Looking back we can see that it was almost dawn.

Oliver Wendell Holmes had published in the New England Quarterly of Medicine & Surgery, April, 1843, (Boston) his now famous article on the "Contagiousness of Puerperal Fever". The Journal had a limited circulation and was discontinued within the year. Ten years later Holmes republished the article. He laid no claim to any new discoveries, pointing out that fifty years before White of Manchester and Gordon of Aberdeen had recognized the contagiousness of the disease and cited numerous other writers who had upheld the same thesis, Clarke, Denman, Burns, Young, Hamilton, Good, Waller, Gooch, Ramsbotham, Douglas, Lee, Ingleby, Locock, Travers, Rigby

continued on next page

and Watson. What marks his article as one of the immortal classics of medical literature is the perfection of his literary style and its unanswerable logic. It is a model of deductive reasoning. Ramsbotham in a footnote writes: "The best paper in any language with which I am acquainted is by Doctor Oliver Holmes (sic) . . . It is a masterly performance and well worth perusal by any skeptics on the subject."

Granted that the disease was contagious, the answers to two questions, based on the bedrock of fact rather than the sands of theory, after thousands of years and millions of needless deaths, were in a short space of less than one hundred years to make a death from puerperal fever a rarity. The questions were 1) the nature of the contagion and 2) the manner of its transmission. Semmelweiss was to answer the second of these two questions thirty-two years before the first was to be answered by Pasteur. As Holmes had proved by unanswerable logic what others had long believed, Semmelweiss was to prove by an irrefutable clinical demonstration what others had seen dimly. He swept aside the non-essentials and placed the emphasis where it belonged. In 1847 he was an assistant in the Vienna Lying In Hospital. The mortality from puerperal fever was frightful—about 10%. He noted that in the first clinic where students were in attendance, the motality rate was much higher than in the second clinic where patients were cared for by midwives. The clinics were in the same building and in all other respects were operated under the same conditions.

In March, 1847, his friend Kolletschka died of an infection following a prick from a knife while performing an autopsy. Findings postmortem were identical with those found in puerperal fever. Students were going directly from the morgue and dissecting room to the lying in wards of the first clinic. He concluded that puerperal fever was a wound infection carried by students and doctors from the autopsy and dissecting rooms to the wards. To Semmelweiss goes the immortal honor of having stated for the first time in history precisely and unequivocally the nature of the contagion, the site of infection and the mode of its transmission.

"The site", he says, "of the infection (the wound) . . . is the internal os of the uterus and upward from there. The inner surface of the uterus . . . is robbed of its mucosa and presents an area where absorption occurs with extreme readiness. The other parts of the mucosa are well clad with epithelium and do not absorb unless they are wounded. If it is injured any part of the genitals becomes capable of absorption." Note carefully that he recognized both physiological and traumatic wounds as ports of entry.

He believed that he had "irrefragable proof of my opinion that puerperal fever originates in the carrying over of decomposed animal organic matter . . . on the finger, operating hand, the bed clothes, the atmospheric air, sponges, the hands of midwives and nurses which come in contact with the excrements of sick lying-in women or other patients—in a word the carrier of the decomposed animal organic material is any thing which can be rendered unclean by such material and then come in contact with the genitals of the patients".

He thereupon forebade students to enter the lying-in wards while doing anatomical dissections. They were required to wash their hands in chlorine water before examining or delivering patients. Only clean linen was to be used in the wards. These procedures caused a drop in mortality from puerperal fever from 11.4% (1846) to 3% in two weeks and subsequently to 1.28%.

Here then was the complete answer to our second question "how was the contagion carried?" No new principle in prophylaxis during labor and the puerperium has been discovered since his original technique. There have been many refinements but the principle that "the carrier of the infectious material is any thing which can be rendered unclean by such material and then come in contact with the genitals of the patient" must forever remain unchallenged—one of the great clinical triumphs of all time.

While the question of what was the nature of the infecting agent carried by the decomposed animal organic matter was not answered by Semmelweiss, an answer was not essential to the development of an effective prophylactic technique.

How Semmelweiss was vilified by his enemies who, unlike him, refused to acknowledge that they had been carriers of infection, how he was driven from one post to another and how he finally died in an insane asylum is another and tragic story.

In 1879—thirty-two years after Semmelweiss showed that decomposed animal organic matter carried the contagion of epidemic puerperal fever—Louis Pasteur obtained pure cultures of the streptococcus from cases of puerperal fever. At last it was scientifically demonstrated that puerperal fever was a transmissable disease and the dissenters were forever silenced.

With the two questions, How is the contagion carried and what is its nature answered, all the facts essential to the development of a perfect prophylactic technique were established. It is to Lister that credit is given for first evolving a technique specifically aimed to prevent the contamination of traumatic and surgical wounds by bacteria—first by pure carbolic acid in compound fractures, later

with antiseptic dressings, and then with his carbolic spray. By 1887 he had become convinced that the role of airborne bacteria was a very minor one and discarded his spray.

Englemann states that Tarnier of forceps fame, tried to apply the antiseptic technique to obstetrics but his work went unheeded and it was not until Stadtfeld of Copenhagen in 1870 applied it on a large scale that the antiseptic technique began to be accepted in obstetrics.

From that time on, no qualified obstetrician doubted that asepsis, that is the exclusion of living bacteria from the operative field, was the objective to be attained. The methods employed to attain that objective have changed over the years. Multifarious chemical agents have gradually given place to heat as the main reliance in sterilizing instruments, linen, gloves, etc., until today alcohol to the hands after scrubbing and before putting on gloves, a mild antiseptic to moisten swabs used to cleanse the perineum of infected discharges and fecal matter during labor and one of the modern antiseptic dyes as an external spray and instilled into the vagina before any operative procedures are all that are left of the chemical antiseptics still in common use.

When the teachings of Holmes, Semmelweiss, Pasteur and Lister had become generally accepted, epidemics of puerperal fever in both hospital and private practice practically disappeared. An occasional case occurred despite the utmost care in sterilizing all instruments, linen and dressings, in cleansing the patient and in scrubbing and disinfecting the hands of the operator. It had been demonstrated that the healthy vagina was teeming with potentially pathogenic bacteria. Why not sterilize the vagina also? There followed an era of antepartum, intrapartum and postpartum vaginal and uterine douching with various antiseptic solutions. About the turn of the century it had become evident that it was impossible to sterilize the vagina and clinical experience had proved that the morbidity was higher in the clinics where douching was practiced than where it was not.

A few years later Williams and others taught that if the normal non-pathogenic bacterial flora of the perineum and lower vagina was transferred to the upper vagina and the traumatized cervix it might become pathogenic and urged that the progress of labor be followed with the minimum of vaginal examination, the main reliance being placed on abdominal palpation. While external palpation might be adequate for normal labors it was only the descent of the presenting part that could be followed. By employing rectal examinations the present day obstetrician avoids the dangers of repeated vaginal examinations and conducts practically all of his non-operative labors without a single vaginal examination.

About the same time it was demonstrated it was impossible to sterilize the hands and that the sweat carried bacteria from the deep layers of the skin to the surface. The use of sterilized rubber gloves was the solution of that problem in the vaginal examinations still occasionally necessary and in operative deliveries.

A few years ago there was an epidemic of streptococcus infections in one of the surgical services of a large metropolitan hospital. One of the operating team was found to be a streptoccus carrier. It was demonstrated that Petri's dishes, at some distance from his face were infected if he talked and the number of colonies was markedly diminished if his nose and mouth were masked. Today masking the nose and mouth is routine procedure in delivery rooms. If one believes in airborn infection he can have ultra violet lights installed in his operating room.

Some fifteen years ago in discussing a paper in Boston at a meeting of the New England Hospital Association I made the statement that in obstetrics a perfect aseptic technique had been evolved and, granted there had been no break in technique, any case of sepsis was due to auto-infection and for the elimination of such cases we must look to the immunologist and the pharmocologist. Since then the dieticians have shown us that vitamins play a part in determining the patients' resistance to infection and we have penicillin as a prophylactic and a curative agent. In the three years since penicillin came into common use in 1944, there has not been a single case at Providence Lying In Hospital in which puerperal infection was a primary or contributing cause of death. But just a moment before we jump to conclusions. Neither did we have any such deaths in 1940, 1941 and 1942. We were getting along quite well before penicillin was on the market. What role the sulfa drugs have played it is impossible to determine but their use both as a prophylactic and curative agent would appear to be indicated.

If the occasional cases of sepsis which still occur are to be eliminated we must hark back to Semmelweiss' teaching of a hundred years ago—not to his teaching that puerperal fever is a wound infection and transmitted by decomposed animal organic matter for that is a lesson that has been so thoroughly learned that it has become a part of our subconscious thinking; not to his teaching that the interior of the uterus had been stripped of its epithelial lining and "presents an area where absorption occurs with extreme readiness" but rather to his dictum that "the other parts of the mucosa (of the genital tract) are well clad with epithelium and do not absorb unless they are wounded. If it

continued on page 246

TUBERCULOSIS IN PROVIDENCE

PETER F. HARRINGTON, M.D.

The Author. *Peter F. Harrington, M.D., of Providence. Director of Division of Tuberculosis, Providence Health Department; Chief of Tuberculosis Department, Charles V. Chapin Hospital.*

UNTIL 1940 the control of tuberculosis in Providence was under the supervision of the Providence Tuberculosis League, and was supported by contributions from the patients attending the clinic, by donations, by a portion of the funds obtained in the sale of Christmas Seals, and by a budgetary allowance from the Community Fund. Under the persistent activity of Dr. John Pinkney and his staff, real progress was made in the control of tuberculosis in our community. Evidence of this is found in the City Registrar's Reports which shows the death rate from tuberculosis in 1939 was 47 per 100,000 whereas it was 80 and 157, in the years 1929 and 1919 respectively.

In 1940, however, the responsibility for the control of tuberculosis was rightfully assumed by the Providence Health Department. In 1941 the writer was named to direct this new activity. It is the purpose of this paper to acquaint the medical profession with the status of tuberculosis in Providence and the changes in morbidity and mortality that have occurred during the past seven years.

At the present time, the Health Department conducts a diagnostic clinic at the Charles V. Chapin Hospital four times weekly; e.e. Monday, Wednesday, Friday mornings and Tuesday evenings. Any and all citizens of Providence are eligible for examination. Patients attending the clinic are referred to it by their private physicians, hospitals, clinics, and public health nurses.

SUMMARY OF ACTIVITY OF PULMONARY CLINIC, 1941-1947

	Patients Attending	New Patients	No. x-rayed	TBC Skin Test	Home Visits DNA	HD
1941	2290	590	1040	145	8876	300
1942	4058	1200	2111	300	6884	450
1943	4435	1059	2438	504	6134	*360*
1944	4597	914	2423	498	4899	*395*
1945	4266	710	2287	814	4958	*515*
1946	4527	669	2424	337		7466
1947	4758	708	2507	380		9022

TABLE I

Table I summarizes the activity of this clinic. It is noted that from 1941 to 1945 the home visits were made by the Providence District Nursing Association. In January, 1946, however, this work was taken over in its entirety by the Health Department and since then the Public Health Department nurses have made the home visits.

The figures recorded in Table II are for all residents of Providence wherever diagnosed. The peaks are reached in the year 1943 and 1945 respectively, and reflect the activity of the Selective Service examinations on the one hand, and the increased number of servicemen who acquired the disease while in service on the other. The comparatively low figure for 1946 is understandable for the conditions producing the high figures during the war years were not operating. The percentage of the total (expressed in italics) shows a greater perponderance of infected males than females, during the early period of selective service when practically all males between 18 and 45 were being examined. As the selective service activity decreased the incidence among females assumes more importance. The diagnosis of others forms (O. F.) than pulmonary is lower during the period when the diagnosis was made on the basis of the film alone. From 1942 to 1946 the cases of pleural tuberculosis as distinguished from those with pulmonary disease were grouped with other forms.

Table III divides the cases diagnosed into age groups. Nineteen forty-two to 1943 shows a greater percentage between 20-44 years of age than the preceding or following years when a far greater number were reported in the age groups over 44 years.

The few preceding tables reflect the incidence of the disease as reported to the Health Department. The figures do not indicate the actual number of active cases of tuberculosis. All of the reported cases do not have active tuberculosis. The diagnosis is made on the basis of x-ray findings of lesions which resemble tuberculosis. It is obvious

PROVIDENCE RESIDENTS REPORTED AS HAVING SECONDARY TUBERCULOSIS
1941 THROUGH 1947

	Total	White	Non-White	Male	Female	Pul.	O.F.	Pleurisy Only
1941	330 % *100*	308 % *93.*	22 % *6.7*	228 % *69.1*	102 % *30.9*	289 % *87.6*	9 % *2.7*	32 % *9.7*
1942	345 *100*	322 *93.3*	23 *6.7*	249 *72.2*	96 *27.8*	339 *98.2*	6 *1.8*	0
1943	459 *100*	433 *94.1*	26 *5.9*	351 *76.3*	108 *23.7*	456 *99.4*	3 *0.6*	0
1944	383 *100*	355 *92.7*	28 *7.3*	251 *65.5*	132 *34.9*	375 *97.9*	8 *2.1*	0
1945	424 *100*	395 *93.1*	29 *6.9*	297 *70.0*	127 *30.0*	407 *96.0*	17 *4.0*	0
1946	194 *100*	175 *90.2*	19 *9.8*	122 *62.8*	72 *37.2*	180 *92.8*	14 *7.2*	0
1947	243 *100*	217 *89.3*	26 *10.7*	147 *60.5*	96 *39.5*	223 *91.8*	16 *6.6*	4 *1.6*

TABLE II

that in further investigations it was found that in some of these cases the diagnosis was incorrect or could not be proved. It is not necessary always to prove the lesion, in fact, we are pleased when we cannot prove it, for in such cases we know that the patient's disease is not active or contagious, and the patient is not a menace to his associates. The inactive lesions help us to find the source of the previously unknown on unrecognized tuberculosis among the diagnosed person's associates or family.

In Table IV, however, some idea of how the cases are categorized for study may be obtained. Those listed as Inactive are unlikely to have had any evidence of active disease in the past several years. Those cases reported which are suspiciously active are classified as active until proven inactive by further study. If only those cases which were proven to be active were reported, the number would be closer to 75 than the 133 given here.

continued on next page

PROVIDENCE RESIDENTS REPORTED HAVING SECONDARY TUBERCULOSIS
BY AGE — 1941 THROUGH 1947

	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-44	45-54	55-64	over 65	N.S.	*TOTAL*
1941	1 % *0.3*	3 % *0.9*	3 % *0.9*	19 % *5.8*	38 % *11.5*	33 % *9.9*	36 % *10.9*	45 % *13.7*	75 % *22.7*	43 % *13.1*	34 % *10.2*	0	*330*
1942	2 *0.6*	1 *0.3*	1 *0.3*	16 *4.6*	42 *12.2*	54 *15.6*	36 *10.4*	83 *23.9*	56 *16.2*	44 *12.8*	10 *2.9*	0	*345*
1943	0 *0*	0 *0*	2 *0.4*	33 *7.2*	68 *14.7*	66 *14.4*	61 *13.2*	91 *19.7*	47 *10.1*	40 *8.7*	22 *4.7*	29 *6.3*	*459*
1944	2 *0.5*	1 *0.3*	4 *1.0*	32 *8.3*	26 *6.8*	43 *11.2*	49 *12.8*	77 *20.1*	77 *20.1*	41 *10.6*	27 *7.1*	4 *1.*	*383*
1945	3 *0.7*	3 *0.7*	2 *0.5*	17 *3.9*	31 *7.3*	43 *10.1*	34 *8.0*	78 *18.5*	97 *22.8*	63 *14.7*	34 *8.*	19 *4.4*	*424*
1946	1 *0.5*	2 *1.0*	1 *0.5*	14 *7.2*	19 *9.8*	17 *8.8*	22 *11.4*	27 *14.0*	46 *23.9*	28 *14.5*	15 *7.7*	0	*192*
1947	2 *0.8*	5 *2.0*	1 *0.4*	16 *6.6*	23 *4.4*	30 *12.3*	20 *8.0*	45 *18.5*	36 *14.8*	39 *15.9*	24 *9.8*	2 *6.8*	*243*

TABLE III

NUMBER OF NEW CASES REPORTED FOR PROVIDENCE

1947	Pulmonary Tuberculosis Active	Pulmonary Tuberculosis Inactive	O.F. Tuberculosis Active	O.F. Tuberculosis Inactive	TOTAL
Jan.	7	9	0	0	16
Feb.	8	10	0	0	18
March	10	4	3	0	17
April	10	5	4	0	19
May	8	5	0	1	14
June	12	21	2	0	35
July	10	8	1	1	20
Aug.	7	0	2	0	9
Sept.	8	9	1	0	18
Oct.	11	18	2	0	31
Nov.	16	11	2	0	29
Dec.	8	8	1	0	17
TOTAL	115	108	18	2	243

TABLE IV

The mortality statistics, however, are for the most part proven. Table V shows the number of deaths and the death rate of Providence residents who died within the confines of the city and those residents who died elsewhere. Except for 1943 and 1944 when a slight temporary swing back toward the total of 1941 occurred, there has been a gradual decline in resident deaths. This in the face of the truly trying and health taxing conditions which existed during the past several years is a notable achievement for this most densely populated city. The deaths recorded for Warwick are chiefly those occurring at the St. Joseph's Annex at Hillsgrove. Those deaths occurring at Cranston for the most part are from the State Hospital for Mental Diseases. There is serious doubt among us that these deaths should appear against our records, since these patients were mostly long term residents at that institution and do not reflect the conditions of tuberculosis in Providence.

DEATH OF PROVIDENCE RESIDENTS BY AREAS—1941-1946

	Providence	Warwick	Cranston	Burrillville	*Otherwise* Outside Providence	Total
1941	75	1	13	39	5	133
1942	65	2	10	33	9	119
1943	66	0	10	40	5	121
1944	60	0	10	49	12	131
1945	60	2	14	27	8	111
1946	58	1	14	28	8	109
1947	*48*	*1*	*17*	*23*	*9*	*98*

TABLE V

If these deaths were eliminated from our statistics, Providence would surely head the nation in cities of any comparable size. The Burrillville deaths are from Wallum Lake and are rightfully accepted in Providence's vital statistics.

Table VI gives the over-all mortality picture for the city during the years of the study. The reduction in death rate from over 50 per hundred thousand to the 1947 figure of 36 is much more impressive than the national figures as presented in the United States Public Health Bulletin. They are still more creditable when we realize that deaths are attributed to tuberculosis when the term is found on the legal death certificate in many cases even though tuberculosis was inactive or only a relatively insignificant factor. We make every effort to include cases as tuberculosis deaths as long as they are in accord with the international standards for death nomenclature. Thus we accept as tuberculosis deaths those which are classified merely as pulmonary hemorrhage, inactive tuberculosis and other respiratory ailments without specific terminology.

DEATHS AND DEATH RATES FOR ALL RESIDENTS OF PROVIDENCE—1941-1946

	Deaths in Prov.	Rate per 100,000	Deaths Outside City	Total Deaths	Rate *per 100,000*
1941	75	29.5	58	133	51.7
1942	65	25.0	54	119	45.9
1943	66	25.3	55	121	46.4
1944	60	22.8	71	131	49.8
1945	60	22.64	51	111	41.88
1946	58	21.43	51	109	40.97
1947	*48*	*18.05*	*50*	*98*	*36.8*

TABLE VI

SUMMARY

Tuberculosis appears to be under satisfactory control in Providence. Improvement is being made in the vital statistics which are the only yardsticks which we have in this disease. That such creditable progress can be continued is problematical now. In recent years there have been fewer beds available for active cases. This means that more patients with active disease must remain at home where they undoubtedly will infect others who come in contact with them.

The progress being made in tuberculosis control is due in no small measure to the cooperation of private physicians in permitting the health officials to step in to educate and follow up the families of diagnosed cases.

SYMPOSIUM ON RHEUMATIC FEVER AND HEART DISEASE*

EARL F. KELLY, M.D., BANICE FEINBERG, M.D., FRANCIS V. CORRIGAN, M.D., JOHN F. KENNEY, M.D.

EARL F. KELLY, M.D.

Chief, Pediatric Department, The Memorial Hospital

WHEN we take into consideration the importance of rheumatic fever and rheumatic heart disease, it is necessary for us as physicians to keep it foremost in our mind, for two reasons: (1) Because it is the leading causative factor of death in children between the ages of five and fourteen years and (2) the medical entity has been neglected by us and has received very little attention in the past. We, in this hospital, feel most interested in this subject and because of the efforts of the Rhode Island Children's Heart Association and the contributing help from the Maternal and Child Welfare Department in the state of Rhode Island, we have established a clinic in this hospital, and a series of clinics throughout the state, together with convalescent homes, for the study and evaluation of the cases referred that are suspected or have had the disease. We attempt to make a complete diagnosis, prescribe the course of treatment and establish a program for the child for the future. I will attempt to bring out to you the importance in making a proper diagnosis because no child should have the stigma placed upon him of having rheumatic fever or rheumatic heart disease without tangible evidence. The importance of the subject cannot be overemphasized because as Thomas Parran, Surgeon General of the United States stated in a recent article, "in the past war, a half million young men were rejected because of rheumatic fever. Also 31,000 cases in the American Navy and Army from 1941 to 1945 were diagnosed."

According to statistics, heart disease has come from the fifth in 1900 to the first place as a causative factor of death at the present day, and it is of interest to us as pediatricians and medical men that it is the leading cause of death in children between the ages of five and twelve. As physicians, we owe it to the public and to ourselves and to the children of the community to keep the subject in mind.

Our state of Rhode Island has been recognized as one of the leading if not the leading state that has made attempts to combat this disease.

Now the symptoms of rheumatic heart disease or rheumatic fever are important as I have said before. We cannot overemphasize the importance of keeping them in mind especially in an area like Rhode Island and New England where the manifestations of the disease are more common than other sections of the country. The disease rarely occurs before the fourth year of life and family incidence is an important factor especially when we recognize that over 50% of the cases have a family history obtainable. At the present time, it is thought that some form of streptococcus is the underlying causative factor. The first attack may escape unnoticed and also with no damage to the heart although the clinical manifestations may be found in the nervous system, the heart itself or the joints, singly or together. I will attempt to review the symptoms now briefly. They may be present in the pattern of other acute illnesses but by careful study we should be able to arrive at a true diagnosis—the temperature in the large number of cases is between 100 and 102°F, and in the beginning is not explainable. General malaise, restlessness, fretfullness, loss of appetite, rapid pulse which is out of proportion to the rise in temperature together with sore throat and moderate leukocytosis, rarely over 25,000; we may have joint symptoms, epistaxis and skin manifestations such as purpura. The above symptoms may remain for a few days and the joint symptoms may appear after several days and at this time, there may or may not be evidence of cardiac involvement. If we are suspicious of rheumatic fever or rheumatic heart disease, it is at this point when the above symptoms are present that we are tempted due to pressure both by the child and parents to forego any further investigation and to let the child become convalescent too early. In over one-half the cases suspected, we may with careful investigation discover cardiac damage. Even though we realize that a small number of these cases of rheumatic heart disease are fatal during the first attack, it is, nevertheless, of the utmost importance to have them admitted to the hospital for further study of the blood, the heart by the roentgenologist, the

continued on next page

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examination by the E.K.G., and careful nursing observation because each and everyone of these cases are of the utmost importance.

Now as for the treatment and the role of antibiotics my colleagues will present to you the uniform method treatment employed in this hospital and in the other hospitals throughout the state.

BANICE FEINBERG, M.D.
Visiting Pediatrician, The Memorial Hospital

IN VIEW of the accepted association of the H.S. as an etiological factor in rheumatic fever the question is repeatedly brought up "Are the sulphonamides and penicillin of value in the treatment of this disease?" Though it is difficult to prove that they are positively harmful, there is little doubt that they do no good. In my own experience, I have never seen any benefit from their use in the treatment of this disease per se. And since these drugs carry with them certain dangers, I feel therefore, that they are definitely contraindicated. In fact some observers definitely feel that the sulphonamides in particular, have aggravated the disease.

When one realizes that Rheumatic Fever generally follows the H.S. infection by about 10-20 days, and that by the time the disease itself has developed, positive throat cultures are difficult to obtain, and if the tenet that the disease is an allergic response to a previous H.S. infection, is true, it becomes obvious why these agents should be of little value.

However, in the treatment of complications and in prophylaxis these antibiotics play an important role.

Complications such as pharyngitis, infected teeth, otitis media, etc., are best treated by sulphonamides or penicillin in full dosage. Prior to T & A, and dental extractions or any other surgery of upper respiratory tract, it is wise to premedicate and post-medicate with these drugs. Positive throat cultures with H.S. is a frequent complication, and are apt to be followed by recurrent rheumatic infections. In the past these have been very difficult to treat. The sulphonamides would take 2-3 weeks and often longer to render these cultures negative. At Crawford Allen, one of our convalescent homes for Rheumatic Fever children, we've been often plagued by positive cultures, following in particular visiting days. This has been considerably reduced by cutting down our visiting to once a month during the winter and early spring months. All our positive cultures are isolated. At first sulphonamides, sulpha gum, penicillin troches, and finally penicillin injections have been used to clear up these throats. After considerable experimentation we now are able to clear these up in 3-5 days with 1,000,000 units of penicillin divided in doses of 40,000 units q 3 hours. At first we tried dosage of 20,000 units q 3 hours, but it wasn't until we got up to the 40,000 unit dosage, that our results became fairly satisfactory.

In long term prophylaxis much has been written and investigated about the use of sulphonamides. In the brief time alloted to this discussion only a brief summary is possible. The results of many independent observers in many parts of the country indicate an appreciable drop in the recurrence rate in those youngsters getting daily dosage of sulphonamide over a long period of time. The drug has been given as long as 5 years. The incidence of severe reactions is negligible. Most of the reactions can be watched for and prevented by a definite program of observation. During the early part of this period the child is seen weekly by the doctor. Weekly blood counts and urinalyses are done. The mother is given a list of instructions. After 8 weeks, the child comes in monthly and later every 3 months.

Sulphadiazin and sulphamerazin have been used in a large number of the children at our clinics since 1942 and as yet we've had no accidents. There have been a fair number of children who had mild reactions such as rashes, nausea, and tendency to low white counts. In all of these the symptoms immediately disappeared upon withdrawal of the drug.

In view of the fact that this disease, in the vast majority of instances hits the poor man's home where large families live in small and crowded quarters, where respiratory infections are apt to be rampant, more than general hygienic measures are necessary. The use, therefore, of sulphonamides, in selected cases, where there is close cooperation and understanding by the parents, is very desirable.

Sulphadiazin in doses of gm. ½ twice daily or sulphamerazin gm. ½ once a day seems to give a blood level of about 2 mgm. percent which seems to be satisfactory for this purpose. Since respiratory infections, though less frequent, do occur in summer time as well, it is best to continue the drug all year round. This also eliminates the need for close observation at the beginning of treatment each year for question of sensitization.

FRANCIS V. CORRIGAN, M.D.
Chief, Division of Maternal and Child Health, R. I. State Department of Health

THE STATE RHEUMATIC FEVER PROGRAM began in December, 1941. The first clinic was held in this hospital on December 31, 1941.

The State Program offers to all accepted on the Program complete care, that is, all necessary hospitalization, convalescent care, foster home care, and medical care while the patient is on the Program. All patients accepted have rheumatic fever or rheumatic heart disease, or conditions that may lead to rheumatic fever or rheumatic heart disease.

Patients with uncomplicated congenital heart disease are not accepted on the Program.

Since the Program was inaugurated in 1941, we have accepted 620 children, 366 of whom have rheumatic fever or rheumatic heart disease; 46 possible rheumatic fever or rheumatic heart disease; 86, potential heart disease; 7 with chorea, and 115 who have no heart disease. You might expect that with better diagnosis, the availability of funds to properly care for these patients, the greater awareness of both physicians and parents to the danger of this disease, we would see an improvement in the mortality tables for deaths due to rheumatic conditions. Such has not been the case.

	Total Rheumatic Deaths	Under Age 25	Over 60	25-60	Females
1944	67	12	20	35	41
1945	69	13	24	32	45
1946	59	12	16	31	37

During the past three years, there has been no change in the number of deaths under age 25; no significant change in the age group 25-60 years, but there has been a small decrease in the number over 60 who have died from some rheumatic condition. Each year over 60% of the deaths have occurred in females.

However, all of us who are participating in this Program feel that the Program has improved the physical condition of the majority of the children who are under this service.

Of the 101 children who have had convalescent care at Crawford Allen, not one child has failed to gain many pounds in weight and benefited both mentally and physically.

We have had 29 recurrences, and we feel that prolonged care has reduced the number of recurrences.

Eight patients have died while on the program.

In Rhode Island, we have provision for the hospitalization of all children under 21 years of age during the active phase of rheumatic fever or rheumatic heart disease, and we have convalescent facilities for the care of the rheumatic child under 12 years of age.

We have many physicians who are qualified to make the diagnosis of Rheumatic Fever and Rheumatic Heart Disease, and now we feel that we have the background to make intensive studies in the epidemiology of Rheumatic Fever.

JOHN F. KENNEY, M.D., F.A.C.P.
Former Chief of the Medical Division, The Memorial Hospital

I AM PLEASED to take part in this symposium and feel that we as physicians should closely cooperate in the care of the cardiac patient, particularly, in the stage of the disease when the pediatrician feels that he should relinquish the patient to an internist or a cardiologist.

To the lay mind, heart disease denotes inevitable and very probable sudden death, and so the individual patient with the stamp of heart disease may live a life filled with fear. Unfortunately, the fear is not always confined to the laity, that almost any body activity is a potential, if not actual danger to the cardiac patient; so to fear is added a very restricted range of activity. Actually, in my years of practice, I have seen many patients who have suffered mental anguish and limited their activities of life, in whom I could detect no signs of cardiac lesion suggestive of any real disease of that organ.

Patients are seriously disturbed by results of a copy of the so-called health examination or having been turned down by a hurried examination for insurance, and at least become mental invalids and many times suffer an economic loss because of limitation, if not ordered by the doctor, is put upon by the patients themselves.

A good thorough history and physical examination by a physician and in questionable cases backed up by laboratory tests as E.K.G., vital capacity, x-ray, etc., is important. Again too often, a patient is given an E.K.G. report when the physician

continued on next page

making it is not competent to interpret the findings. The physician should be broadminded enough to refer such cases to a man competent in the field and correlate his findings with the physical examination, and then add common sense to the application of skilled methods and interpret them to the patient.

We are all familiar, or it has been described to you, with the typical attack of rheumatic fever in the child or young adult. It is when the symptoms are slight, or when they occur in a mild form, or a mild sore throat untreated, that history taking is so important. Atypical cases which fail to be recognized are responsible for many cases of valvular heart disease such as repeated epistaxis in children, and vomiting attacks with abdominal pain.

S. A. Levine claims that we should look upon rheumatic fever in many respects similar to syphilis and cites the case of a small child recovering from a slight attack of rheumatic fever, diagnosed or undiagnosed, and 20 years later showing marked symptoms of mitral stenosis, and of a young adult with a chancre and 20 years later showing symptoms of aortic insufficiency. The familial tendency to rheumatic fever should not be overlooked as also the regional and seasonal disturbances and constitutional factors of the patient.

Prevention has to be considered in any discussion such as this. I feel strongly, that nutrition, that is ,proper food, rest and dry clothing and feet, should be put first in any campaign to lower incidence of rheumatic fever, and confess that we see more rheumatic hearts in chidren that do not receive proper care than in the robust well cared for child. The problem of tonsillectomy in prevention of first attack or of subsequent attack is debatable and in my own experience, and from looking up statistics in the past, I am convinced we cannot rely on this. Climate, I feel, is of value in prevention of first attack.

No attempt is made in this discussion to bring out any diagnostic points, except to say that this is one condition that you will receive positive help from the E.K.G. when some of the other symptoms or diagnostic points are doubtful.

The subject of rheumatic fever and rheumatic heart disease is a tremendous one and I have only been able to bring out a few features in the brief time allotted.

CONQUEST OF PUERPERAL INFECTION

concluded from page 239

is wounded any portion of the genitals becomes capable of absorption." When and only when obstetricians keep this dictum in mind, keep operative procedures at a minimum and operate only after the natural forces of nature have accomplished the greatest dilatation and descent possible or have substituted low flap or extraperitoneal hysterotomy for brutal delivery from below, will death from puerperal infection be further reduced.

The history of puerperal infection is but another illustration that a truth, unlike Minerva, seldom springs full panoplied from the head of Jove but is evolved by the elimination of many untruths and the slow accretion over many years of many partial truths. It is an illustration in miniature of the universality of science which knows no color, creed or race, no national boundaries. To four men above all others must go the credit for the conquest of puerperal infection: Holmes, an American; Semmelweiss, an Hungarian; Pasteur, a Frenchman and Lister an Englishman. How many thousands, indeed how many millions of women owe their lives to these men and their colleagues no one knows.

If the ratio of one death in twenty-nine deliveries as reported by LeFort (1870) in the hospitals in Paris had prevailed in the Providence Lying In Hospital in the years 1937-1946 there would have been 1493 deaths. There were actually fifty-two. These figures are for deaths from all causes. If the mortality rate of 11.4% from puerperal fever in the year 1846 in the first clinic of the Vienna Lying In Hospital had prevailed over the same ten years there would have been 4941 such deaths. There were nine.

In his biography of Semmelweiss published in 1909 Sir William J. Sinclair says: "In the whole History of Medicine we find a clear record of only two discoveries of the highest importance in producing direct and immedite blessings to the human race by the saving of life and the prevention of suffering. These were the discoveries of Edward Jenner and Ignaz Phillip Semmelweiss." If he were writing today he undoubtedly would add other names to his role of honor but it is still true that the conquest of Puerperal Infection is one of the greatest triumphs in the whole History of Medicine.

FROM RHODE ISLAND TO AFRICA

Will someone please find us a correspondent in darkest Africa, say about the headwaters of the Congo. A few months ago we received and printed an article from the Egyptian Sudan. Now Dr. S. V. Humphries, Van Dyke Mine, Boxsburg, Transvaal, South Africa, wishes to reproduce a portion of Dr. Damarjian's article on Brachial Plexus Block. If one of our veterans will write on the Tsetse Fly perhaps we can interest the center of the continent.

The RHODE ISLAND MEDICAL JOURNAL

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OVER-TREATMENT AND GUNSHOT PRESCRIPTIONS

Dr. Holmes said somewhere that Homeopathy came to this country at an opportune time. This was not because he believed in the divided doses of Hahnemann but he disbelieved in the enormous use of drugs then so common. After speaking of the achievements of the young U. S. A. he said, "What wonder that the stars and stripes wave over doses of ninety grains of sulphate of quinine and that the American eagle screams with delight to see three drachms of calomel given at a single mouthful?"

In the early days of the present century "gunshot prescriptions" were popular. Go to one of our long established drugstores and ask to see the slips of those days. Eight or ten ingredients were common. But the profession realized that the analogy between shooting ducks and treating disease was a poor one and this habit was laughed out of use.

Blood and plasma transfusions, intravenous solutions of salt and sugar, hormones, vitamins, sulfa drugs and antibiotics are recent developments and exceedingly valuable ones. But isn't it possible to discriminate safely and not use them routinely in so many cases? The last case we heard reported at a certain medical meeting used every one of these in large doses. We think the patient might have got well had all medication been withheld.

One of the outstanding men in the development of antibiotics was asked in this city concerning the use of penicillin under a certain condition. His answer was, "I don't know, but it can't do any harm so why not try it?" Even were this true it seems like a mighty weak argument but we thought of physician friends of ours who had been made seriously sick by penicillin.

Few doctors have the wisdom of Dr. Holmes. "Presumptions are of vast importance in medicine as in law. A medicine—that is, a noxious agent,—should always be presumed to be hurtful. It always is *directly* hurtful; it may sometimes be indirectly beneficial."

Neck dissections are long drawn out but they don't seem to hurt patients as extensive handling of abdominal contents does. We don't remember seeing any such patient go into shock. Yet in our last case the anesthetist ordered a blood transfusion in a perfunctory routine manner. A man largely instrumental in developing the use of intravenous fluids tells us he is greatly disturbed by their indiscriminate over use. We can recite cases where patients have been drowned by them. Unfortunately, we all know of deaths due to suppression of urine following the use of sulfa drugs. Streptomycin definitely has serious toxic effects not too infrequently following its use.

continued on next page

With our New England background we can't help reflecting that an all wise judgment in the use of these expensive agents would effect a great economy in our hospitals' purchases of red ink.

An able resident in one of our large hospitals told us the other day that they used all these agents "prophylactically". In his bright lexicon of youth doesn't prophylaxis mean trying everything in sight in the hopes that something will do the job?

A few years ago the reproach was often made to the medical profession that our interest was only in diagnosis and that we neglected treatment. The leaders in those days bore in mind the now out-moded words of Sydenham. ". . . nor do I think it below me to acknowledge that, when no manifest indication pointed out to me what was to be done, I have consulted the safety of my patient and my own reputation most effectually by doing nothing at all."

"Those days", said Rand, "are gone totally".

"You said it brother," said Mr. McNally.

CHARLES BRADLEY, M. D.

Dr. Charles Bradley, after fifteen years at the Emma Pendleton Bradley Home, is leaving us to become Associate Professor of Pediatrics and Child Psychiatry at the University of Oregon Medical School. During this period he has been a pioneer in the institutional study and treatment of behavior problems in children, and has established the Bradley Home as a leader in the field. It was fitting that, on the eve of his leaving, the Providence Medical Association should hear one of his papers and give him praise.

It makes us uneasy when a man of Dr. Bradley's caliber moves away. Would it not have been possible to keep him? Could we not have opened a way here for him to have a broader field for action in showing us at the hospitals and elsewhere how to develop the practice of child psychiatry? Or was the call of the West and the appeal of a teaching center too strong?

However this may be, he takes with him our best wishes in his new and tremendously interesting venture and also our gratitude for fifteen years of highly productive labor here. He leaves behind him footsteps that will be a guide to us for many years.

Dr. Bradley's services to the Rhode Island Medical Society have been great. Before our executive secretary took over he arranged with unusual proficiency the commercial exhibits at our Annual Meeting. For nine years he has been a member of the Editorial Board of the Rhode Island Medical Journal. Always cheerfully willing, he responded with alacrity to any call and his contributions and counsel have aroused our appreciation and admiration. The Society and the Journal reiterate the sentiments expressed above for the whole profession of the state.

RESEARCH

The article, "The Conquest of Puerperal Infection," published in this issue is timely because the year 1947 marked the hundredth anniversary of the epoch-making discovery of Semmelweis. The limits of space and time imposed upon an article to be used at a meeting or to be published in a state medical journal require that it be mainly factual and preclude any extended comment on its philosophical implications. Sir William's comment anent the discoveries of Jenner and Semmelweis that in the whole history of medicine up to that time theirs were the only two discoveries of the highest importance in producing direct and immediate blessings to the human race by the saving of life and the prevention of suffering would furnish a text for almost endless philosophizing.

Theirs were discoveries in the field of preventive medicine. Can curative medicine point to any comparable discoveries? Typhoid fever, malaria, typhus, yellow fever, cholera, have all been banished from vast areas of the world's surface where formerly they were epidemic and endemic, all by virtue of preventive medicine.

They were both made without benefit of modern methods of research—the laboratory had no part in their discovery. The virtues of digitalis were discovered by a physician in clinical tests by the gradual elimination of the inert substances in a shotgun mixture which had been successfully employed by a charlatan. No doubt one could point out many other discoveries of a similar nature, quinine, mercury, iodine.

Bedside observation and deductive reasoning lack the glamour of modern "research" with its x-rays, super microscopes, retorts, filters, incubators and what not, but they are as truly "research" and as truly scientific as Research spelled with a capital R. Within a few years studies of the records of a Providence hospital proved that delivery by Caesarean Section in many or most cases of placenta previa was safer than delivery from below. Another study showed that the use of Vorhees' and similar bags to dilate the cervix uteri was often followed by sepsis. Another series showed that a cystogram would show the presence or absence of placenta previa.

These studies, modest though they may be, are truly "Research" and truly "Scientific." Any hospital with an adequate record system may be a centre of clinical research. And after all is not the ultimate objective of all medical research the discovery of facts clinically useful?

COMMUNITY LEADERSHIP

Dr. William A. Horan is one of the busiest men in our profession. So of course it is natural that he has been chosen lay chairman of the Annual Catholic Charity Fund Appeal.

His orthopedic work at St. Joseph's, Charles V. Chapin and Notre Dame Hospitals, the State Department of Health and the State institutions at Howard, certainly constitutes a full time job, but whenever he is appointed to any committee he will be found at the meetings devoting his full attention to the proceedings.

A frequent writer of orthopedic papers he is always clear cut in his ideas and vigorous in promoting them. It can be predicted that he will respond with earnestness and ability to this latest call.

STREPTOMYCIN IN TUBERCULOSIS

Streptomycin has been used long enough to demonstrate that it has a place in the treatment of human tuberculosis. It does not supplant the time tested methods of treatment, however, and in fact is of little or no value in most of the diagnosed cases already under treatment. In the experience of those of us who have used it here and elsewhere it has helped in many cases by reducing toxicity, as manifested by fever reduction and improved sense of well being. In some cases, definite roentgenological improvement has also been noted. It has reduced toxicity which is most important, however, for we still have to accept the proposition that the cure of tuberculosis depends upon the resistance of the person. Toxicity militates against the struggle the body would like to wage to restore the resistance factors the debilitation of which led to the development of the active tuberculous process. If streptomycin did nothing more than shorten the duration of the toxic process, it would in many cases be the critical factor in obtaining a cure. Because of the apparent value of this anti-biotic, in some cases, it is important that some of the present accepted theories regarding its use as disclosed by the Committee on therapy of the American Trudeau Society of administration be summarized.

1. 1.0 gram per day is adequate; smaller doses may be equally efficacious; larger doses may be necessary in the miliary and meningitic form of the disease.

2. Doses given intramuscularly at 6-12 hour intervals are effective. Intra-thecal doses of 50 mgm in meningitis are helpful.

3. Streptomycin should be used
   a) in tuberculous meningitis; hematogenous tuberculosis
   b) more severe cases of tuberculous laryngitis and ulcerating tuberculous lesions of mucous membranes of oropharynx and tracheo-bronchial tree.
   c) Pulmonary tuberculosis
      A. Recent but extensive and progressive lesions
      B. Tuberculous pneumonia
   d) Acute ulcerative tuberculous enteritis
   e) Tuberculous draining cutaneous sinuses

4. Streptomycin is not recommended for:
   a) chronic fibroid or fibrocaseous tuberculosis
   b) Acute destructive and apparently terminal types
   c) Minimal or early moderately advanced tuberculosis with a favorable prognosis
   d) Chronic empyema of tuberculous origin.

5. More study is necessary before its use can be recommended for:
   a) Tuberculosis of the G.U. tract
   b) Tuberculosis of the bones and joints
   c) Tuberculosis of the skin
   d) Tuberculous lymphadenitis without sinus formation
   e) Ocular tuberculosis
   f) Prophylaxis preceding and following surgical procedures.

6. Toxic reactions are not completely understood, and the following have occurred:
   a) Vestibular disturbance,
   b) Deafness (rare)
   c) Renal damage (in presence of pre-existing renal disease)
   d) Cutaneous rashes,
   e) Exfoliative dermatitis

7. Disappearance of drug sensitive strains and replacement with strains that are resistant to known anti-biotic therapy handicaps prolonged therapy.

8. Treatment with streptomycin should be avoided when other effective treatments are available, because to produce a drug resistant strain may possibly interfere with drug treatment of a more serious type of disease.

With these well conceived thoughts as a guide, we will assuredly be better pleased with our results and have a true picture of the real worth of streptomycin.

THE RESPONSIBILITY OF THE HOSPITAL ADMINISTRATOR TO OTHER COMMUNITY HEALTH AGENCIES*

The Author. *Ira V. Hiscock, Sc.D., of New Haven, Conn. Professor of Public Health, Yale University, and Commissioner, New Haven Board of Health.*

FIVE YEARS AGO in discussing the Community Hospital and Public Health[1], I expressed the opinion that nothing was of more importance for the achievement of victory and of peace than the maintenance of mental and physical health on the home front; and emphasized that those at home face mounting burdens which call for alertness, courage, energy, faith, joint planning and cooperative action. Millions have returned victorious from the battlefield to join their relatives and friends on the home front; but the struggle for peace continues and the requirements for able leadership are urgent.

In this setting, the hospital administrator is a very important person. He is engaged in a great business of dealing with human life; he is a part of one of the twelve major industries of the United States. His task is far reaching in scope and significance, touching as it does the economic, religious, scientific and social life of the community. You recall that one person in ten in the United States enters a hospital each year[2] as an in patient and that an even larger number receives attention in out patient departments. Meanwhile, however, there is recognized a great need for locating hospitals in rural regions because of the concentration in cities, and for improving the pattern of their utilization; and for developing coordinated services between large and small hospitals. The hospital has become a place for medical practice, the advantages of which are sought by all sections of the population from the well-to-do who can pay the full cost of care to those who receive entirely free service. Discussion of any phase of community life leads, sooner or later, to a consideration of the hospital where most of our children first see the light of day.

The ability of the hospital administrator to meet the opportunities and responsibilities which he faces daily depends upon his own skill and upon the understanding and support of the public and of his associates within the hospital and the other community agencies. One of the significant groups of associates is of course the Board of the Hospital; and the chances are good that most of the members of this Board are also members of other community health or welfare agencies. In this connection it is well to bear in mind that there are over 20,000 voluntary health agencies in the United States, and that millions of individuals are associated with them.[3]

Many of the mutual interests of administrators of hospitals and of public health programs are assuming increasing importance with the pressure for efficient use of manpower and of all other resources, and with the new advances in the medical and the social sciences. Furthermore, public interest in health has reached a new peak, as has the general appreciation of the benefits of good hospital care. In our joint planning for cooperative action, imagination, flexibility, patience, resourcefulness and skill are demanded.

It is gratifying to observe the leading part taken by administrators in the development of a council plan. A well organized and actively functioning health and hospital council, or the provision of separate councils for health and for hospitals, but with interlocking representation and with provision for joint sessions, facilitates community planning and helps to broaden the horizons of participating agencies. In many communities, such councils or committees are identified with the Council of Social Agencies with which the hospital administrators need to be associated prominently. Among the advantages of such cooperative enterprises are: economy; extension and wider utilization of service; better quality of service; greater possibility for new services through pooling of resources; better use of buildings and equipment; better understanding.

A successful public health program depends upon adequate legislation, adequately trained per-

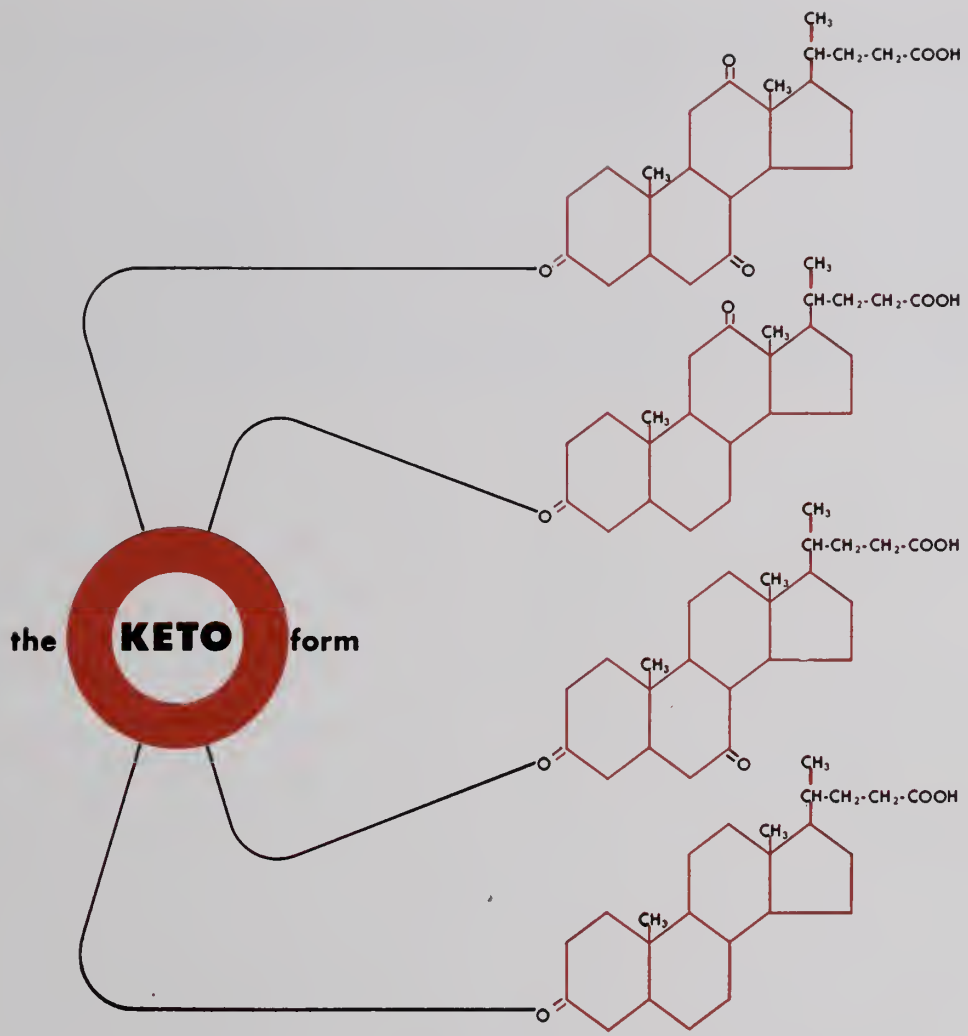
continued on page 252

* Presented at the New England Institute for Hospital Administrators, at Providence, June 28, 1947.

[1] The Community Hospital and Public Health, Hospitals, December 1942.

[2] Medicine is the Changing Order, The Commonwealth Fund, New York, 1947.

[3] Voluntary Health Agencies, The Ronald Press Company, New York, 1945.



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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

RESPONSIBILITY OF HOSPITAL ADMINISTRATOR TO COMMUNITY AGENCIES

continued from page 250

sonnel, adequate funds, and favorable public opinion including the participation and support of the medical, dental and nursing professions. In a similar manner is the success of a hospital administration program influenced. Considering the community as a whole, the mutual interests and responsibilities of health and hospital administrators are significant.

The uneven distribution of medical and health facilities creates problems of common interest calling for measures of mutual concern. The ageing of the population, with a shift in the magnitude of certain diseases and of accidents has not simplified the problem. The growing recognition of the importance of adequately staffed and properly organized industrial medical services adds to the opportunities for constructive services.

If a hospital neglects to report cases of communicable disease there will be delay in the investigation of sources of spread in the community. In some instances there needs to be worked out jointly a more systematic plan between the hospital and the health department with a sympathetic understanding developed between all concerned as to the factors involved. In planning for resources to prevent and to combat outbreaks of poliomyelitis, or to insure proper care of early discharged maternity cases (including provision of visiting housekeeper service) the team work required to study needs and facilities and operation of a program must be formulated wisely. If a crowded hospital is unable to accept reservations for obstetrical cases, especially those from homes not properly equipped for delivery and for the early care of mother and infant, or if nurseries are overtaxed, the alert health officer and the active hospital administrator both become concerned about the hazards to maternal and child health and about relations with the medical and nursing groups. It is important to view the patient as a whole, the family as a unit, and the community as a composite neighborhood.

One of the most common problems discovered in health and hospital surveys is the inadequacy of provisions for the care of convalescent and chronic cases. Another is the striking lack in most communities of medical social service, and the delay in referrals of discharged cases to community nursing or social service agencies to help in the home adjustment, unless the community plan provides for some other adequate follow-up system. There are still isolation hospitals conducted as separate expensive enterprises in communities where an affiliation with a general hospital would be an asset and frequently provide better service at less cost. Perhaps some of those isolation hospitals could be used for more constructive purposes. There are also independently operated clinics and dispensaries, even in communities where general hospitals have more or less adequate facilities of outpatient departments. Services might be strengthened if vested interests and traditions received less emphasis, and if more thought were given on a community basis to the organization of professional staffs. And a final detail, if the official agency or some other group fails to provide sufficient operating funds for the care of indigent cases, or if accepted policies of admission to outpatient departments run counter to more liberal registration provisions of consulting health clinics, the hospital administrator is faced with burdens difficult to solve unless there is machinery for clearance of problems with mutual respect and understanding. These are some of the reasons why every community, to help solve such questions, should provide for some form of representative committee or council, where the workers in different health and hospital agencies may come to know each other. This may serve as a center for discussion of new problems as they arise, as well as for the establishment of policies and administrative plans, and as a clearing house of information for the public. Both health and hospital administrators have a stake in the enterprise.

There is almost an untilled field in the records of hospitals for practical research study of problems of health and disease, of cost and of laws. It is hoped that this fertile source of information may be more fully explored. Meanwhile, systematic records are essential for both hospitals and health agencies. Where cooperative health work involving the care and assistance of patients exists, there should be mutual availability of pertinent facts. For example, considerable information has been assembled concerning the cancer problem for the benefit of patients through the study of clinic, hospital, and vital statistics records by cancer committees in cooperation with the agencies rendering service. Joint utilization of records is common in the fields of maternal and child health, mental hygiene, and tuberculosis. Systematic use of the Index on a regional basis is increasing. Plans and policies for interchange of essential information must be formulated by the groups concerned in the light of local conditions, facilities and personnel in order to insure that the patient's interests are protected while his welfare is promoted. Administrators may contribute much to community welfare by participation in careful studies of hospital and clinic records under scientifically controlled conditions. The proper care and follow-up of patients and the provision of constructive service may be furthered through the maintenance and appropriate confidential use of

continued on page 260

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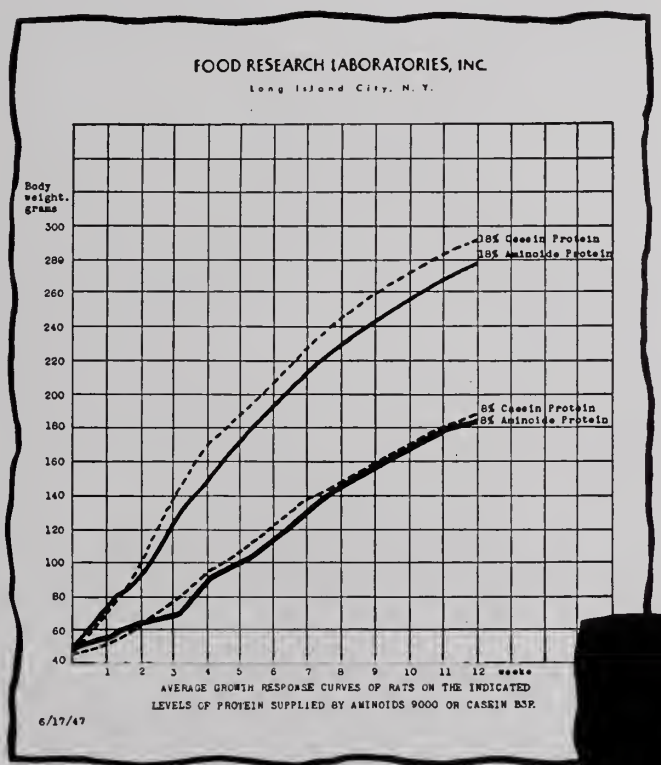
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PROGRAM . . . 137th ANNUAL MEETING

RHODE ISLAND MEDICAL SOCIETY

May 12-13, 1948 *At the Rhode Island Medical Society Library, Providence*

WEDNESDAY, MAY 12

2:00 P.M. CALL TO ORDER

WELCOME BY PRESIDENT, Arthur H. Ruggles, M.D.
RECOGNITION OF DELEGATES FROM OTHER SOCIETIES

Presiding: HERMAN C. PITTS, M.D., *Immediate Past President*

2:15 P.M. "HORMONAL ALTERATION OF ADVANCED CANCER OF THE BREAST"

B. J. KENNEDY, M.D., of Boston, Massachusetts

(Fellow in Medicine, Massachusetts General Hospital; Clinical Fellow, Medical Laboratories of the Collis P. Huntington Memorial Hospital, Harvard University)

2:45 P.M. "THE SURGICAL TREATMENT OF VESICOVAGINAL FISTULAE"

LOUIS E. PHANEUF, M.D., of Boston, Massachusetts

(Professor and Head of Department of Gynecology, Tufts College Medical School; Surgeon-in-Chief, Department of Obstetrics and Gynecology, Carney Hospital; Surgeon-in-Chief, Department of Gynecology, Boston Dispensary, a unit of the New England Medical Center; Fellow, American Gynecological Society, American Association of Obstetricians, Gynecologists and Abdominal Surgeons, International Society of Surgery, etc.)

3:15 P.M. "EFFECTIVE PROCEDURES IN THE TREATMENT OF INJURED HANDS TO PREVENT CRIPPLING DEFORMITIES"

WILLIAM E. BROWNE, M.D., of Boston, Massachusetts

(Clinical Professor of Surgery, Tufts College Medical School; Surgeon in Chief, Second Surgical Service, Carney Hospital; Consultant in Surgery, U. S. Marine Hospital.)

3:45 P.M. INTERMISSION TO VISIT TECHNICAL EXHIBITS

Presiding: ARTHUR H. RUGGLES, M.D., *President*

4:15 P.M. THE CHARLES V. CHAPIN ORATION
"INDUSTRIAL HEALTH"

PHILIP DRINKER, of Boston, Massachusetts

(Professor of Industrial Hygiene, Harvard School of Public Health.)

continued on page 256

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Dosage: One capsule three times daily, or more if indicated.
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BIBLIOGRAPHY· (1) De Lee, J. B. and Greenhill, J. P.. Principles and Practice of Obstetrics, Saunders, Philadelphia, 1947, p. 95. (2) Bicknell, F and Prescott, F.: The Vitamins in Medicine, Grune and Stratton, New York, 1947, p. 663, p. 189, p. 326.

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5:15 P.M. TOUR OF THE TECHNICAL EXHIBITS

6:00-7:00 P.M. RECEPTION . . . . . At the Narragansett Hotel
(For Members of the Society and their Guests)

7:00 P.M. DINNER . . . . . At the Narragansett Hotel
(For Members of the Society and their Guests)

9:00 P.M. *Presiding:* GUY W. WELLS, M.D., of Providence
Anniversary Chairman

Presentation of the Charles V. Chapin Memorial Award:

HONORABLE DENNIS J. ROBERTS
Mayor of the City of Providence

Greetings from HONORABLE JOHN O. PASTORE, *Governor of Rhode Island*

Address: "THE CHALLENGE OF MEDICINE IN THE ATOMIC ERA"

EDWARD L. BORTZ, M.D., A.B., F.A.C.P., L.L.D., of Philadelphia, Pennsylvania

(President, American Medical Association; Associate Professor of Medicine, Graduate School of Medicine, University of Pennsylvania; Member, Board of Governors, American College of Physicians; Honorary Consultant to the Surgeon General of the U. S. Navy.)

THURSDAY, MAY 13

At the Rhode Island Medical Society Library

Presiding: ISAAC GERBER, M.D., *Vice President*

11:00 A.M. "NEUROLOGICAL ASPECTS OF POLIOMYELITIS"

HENRY R. VIETS, M.D., *of Boston, Massachusetts*

(Lecturer on Neurology, Harvard Medical School; Neurologist, Massachusetts General Hospital.)

11:30 A.M. "TECHNIQUE OF CONTINUOUS PERIDURAL ANESTHESIA
(Lumbar Approach)
Illustrated with motion pictures.

HOWARD W. UMSTEAD, M.D., of Pawtucket

(Chief, Anesthesia Department, Memorial Hospital.)

"SPINAL ANESTHESIA IN VAGINAL DELIVERIES"

WALTER J. DUFRESNE, M.D., of Pawtucket

(Senior Surgeon, Obstetrical Department, Memorial Hospital; Chief Obstetrician, Notre Dame Hospital; Courtesy Staff, Providence Lying-In Hospital.)

12:00 BUSINESS MEETING OF THE SOCIETY
INSTALLATION OF OFFICERS FOR 1948-49

12:30 P.M. LUNCHEON (A buffet lunch will be served to members of the Society in the basement dining room)

continued on page 258

IF SHE TOUCHES BUDS THEY WILL WITHER"[1]



Folklore is full of tales of the malevolent power exerted by menstruating women.[1] And certainly many a modern family will testify to the baleful influences of a woman distraught by dysmenorrhea and premenstrual tension.

For centuries, the treatment of painful menses has been empiric and symptomatic. But now endocrine therapy — with the corpus luteum hormone — aims at correcting a basic deficiency. A lack of progesterone results in a different type of uterine contraction, which in turn may explain the labor-like pains of dysmenorrhea.[2] Since it is well established that PRANONE* Tablets have a quieting effect on uterine motility in threatened abortion,[3] this medication is logical treatment for dysmenorrhea as well.

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As PRANONE Tablets are physiologic therapy and simple to administer, they are worthy of trial for dysmenorrhea, premenstrual tension and menstrual neuroses.

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BIBLIOGRAPHY: (1) Chadwick, M.: Nervous and Mental Disease Monographs, Series No. 56, 1932. (2) Torpin, R.; Woodbury, R. A., and Child, G. P.: Am. J. Obst. & Gynec. **54**:766, 1947. (3) Rutherford, R. N.: Am. J. Obst. & Gynec. **51**:652, 1946. (4) Soule, S. D.: J. Clin. Endocrinol. **1**:567, 1941. (5) Greenblatt, R. B.; McCall, E. F., and Torpin, R.: Am. J. Obst. & Gynec. **42**:50, 1941. (6) Harding, F. E.: Am. J. Obst. & Gynec. **50**:56, 1945. (7) Harding, F. E.: Am. J. Obst. & Gynec. **53**:279, 1947.

*℞

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Presiding: JOSEPH C. O'CONNELL, M.D., *President-Elect*

2:00 P.M. "MODERN HEALTH PROGRAMS"

EDWARD A. MCLAUGHLIN, M.D., of Providence

(Director, State Department of Health, President of Rhode Island Infantile Paralysis Foundation; Executive Committee, State and Provincial Health Authorities of North America; Visiting Staff, Rhode Island, St. Joseph's, and Charles V. Chapin Hospitals; Medical Director, Providence Floating Hospital Association.)

2:30 P.M. "CHEMOTHERAPY OF LYMPHOMA AND LEUKEMIA"

WILLIAM DAMESHEK, M.D., of Boston, Massachusetts

(Professor of Clinical Medicine, Tufts College Medical School; Hematologist, J. H. Pratt Diagnostic Hospital; Consulting Hematologist, West Roxbury Veterans Facility; Consultant to the Surgeon-General of the U. S. Army; Editor-in-Chief of *Blood*, the Journal of Hematology.)

3:00 P.M. INTERMISSION TO VISIT TECHNICAL EXHIBITS

3:30 P.M. PRESIDENTIAL ADDRESS:

"MEDICAL LEADERSHIP"

ARTHUR H. RUGGLES, M.D.

(President, R. I. Medical Society; President, National Committee on Mental Hygiene; Past President, American Psychiatric Association, and of the Council of the New England State Medical Societies; Former Superintendent, Butler Hospital.)

4:00 P.M. "THE ETIOLOGY AND TREATMENT OF ULCERATIVE COLITIS"

ANTHONY BASSLER, M.D., F.A.C.P., LL.D., of New York City

(Past Professor, New York Polyclinic and Fordham Medical School; Consultant Gastroenterologist, New York Polyclinic, St. Vincent's, Misericordia, Jewish Memorial, St. Ann's, New Rochelle, and St. John's hospitals.)

ALLIED MEETINGS

WEDNESDAY, MAY 12

At the R. I. Medical Society Library

THE RHODE ISLAND ASSOCIATION OF MEDICAL RECORD LIBRARIANS

Presiding: MISS GERTRUDE CAHR, R.R.L., *President*

10:00 A.M. BUSINESS MEETING

11:00 A.M. "WHAT THE CLINICIAN EXPECTS OF THE RECORD LIBRARIAN"

WILFRED PICKLES, M.D., of Providence
(Chief, Neuro-Surgical Department, Rhode Island Hospital.)

11:30 A.M. "MEET YOUR MIND" A Recording to be discussed by

HUGH KIENE, M.D., of Providence

(Staff member, St. Joseph's, Memorial, Rhode Island, Roger Williams General, Miriam and Charles V. Chapin Hospitals and the State Sanatorium; Former Director of Psychopathic Department, Charles V. Chapin Hospital; Former Clinical Director, State Hospitol, Howard.)



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Pontothenic Acid (as Calcium Pontothenate)	10 mg.
Liver Concentrate* (70% Alcohol-Insoluble Fraction)	0.3 Gm. (5 grs.)
Brewer's Yeast Dried*	0.15 Gm. (2½ grs.)

*For other B Complex Factors

SPECIFY

Sur-bex®

ABBOTT'S VITAMIN B COMPLEX TABLETS

RESPONSIBILITY OF HOSPITAL ADMINISTRATOR TO COMMUNITY AGENCIES

concluded from page 252

informative records in conjunction with other community agencies.

Looking further ahead, and rising above many administrative details is it too much to anticipate that the community hospital may increasingly become a *community* health center? Here and there such an achievement has been partially realized, but we have only begun to tap possibilities. It is certainly not too much to hope that there may be a clear-cut definition and division of functions of all available hospitals and medical resources on a regional basis.

The conservation of public health has long been recognized as one of the essential functions of government; and the authorized force created by a governmmetal unit for health administration is the health department. In the modern scheme, the supervision of care of the indigent sick may be considered as a function of a medical care division of a well organized health department in cooperation with the hospital and welfare agencies. The voluntary agency occupies a place in a community health program for the conduct of certain important activities for which the local official agency is usually not equipped or ready, for the support of adequate standards of service -- a responsibility also increasingly assumed by official agencies — for the dissemination of information to the public, and for experimentation and demonstration in pioneer fields. There are over twice as many general and special hospitals under private control as compared with government ownership. The latter group, with nearly two-thirds of all beds, maintains, however, a preponderance of nervous and mental and tuberculosis institutions which are usually operating at high capacities and have waiting lists.

Advances in public health have come through the development of full time county and district health departments. There are some areas which are too sparsely populated and have inadequate tax resources for the maintenance of full time local health departments, although a combination of towns and even of counties is feasible. The combination of a health and a medical program built around a community hospital has been found practical.

The hospital and the clinic have a responsibility for the education of both patients and personnel. Administrators may stimulate the instruction of mothers before they return home with their babies, a task of immediate importance during this period of emergency. Education in first aid, instruction of nurse's aides, and supervision given to volunteers should have more than immediate benefits for public information and understanding. The clinic offers an excellent opportunity for general health education through visual methods and literature, and for special instruction regarding immunization against disease. We have only begun to train workers in health education for this task. Stimulus may be given to house physicians to take epidemiological as well as purely clinical histories, and to consider the social backgrounds of their patients in relation to other problems.

In a recent bulletin we read that community freedom and community responsibility go hand in hand.[4] The hospital survey and construction act offers tools to provide better medical care for everyone—"to put the man together right"—a big step toward a healthy world—Bearing in mind the objectives of freedom and friendliness and understanding attention is directed to seven additional F's. In summary—we need *foresight* to plan on the basis of *fact* and to enlist the participation of board and staff members who are equipped by *fitness* to assume responsibilities and to display initiative. We need adequate *funds* for the execution of plans having *flexibility;* we need to mix *fun* and relaxation with business, and play together as well as work together; and above all we need *faith* in each other and in our jobs.

[4] The Hospital Act and Your Community, Federal Security Agency, U.S.P.H.S., Washington, 1947.

TUFTS ALUMNI IN R. I. ELECT

On March 3 a dinner was held at the Wayland Manor of the Rhode Island Medical Alumni of Tufts College Medical School. Approximately seventy-five members heard Dr. Harry Blotner, secretary of the Tufts Medical Alumni Association, give an interesting and stimulating review of the future plans of the medical school.

At a business meeting conducted during the session the following were elected as officers for the 1948-49 term:

HILARY J. CONNOR, M.D., *President*
CHARLES J. ASHWORTH, M.D., *First Vice President*
EARL F. KELLY, M.D., *Second Vice President*
THOMAS L. GREASON, M.D., *Secretary*
BANICE FEINBERG, M.D., *Treasurer*

PROVIDENCE MEDICAL ASSOCIATION

Next Meeting
Monday, May 3

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DISTRICT SOCIETY MEETINGS

KENT COUNTY MEDICAL SOCIETY

The February meeting of the Kent County Medical Society was held the evening of the ninth at the Log Cabin Restaurant, West Warwick, Rhode Island.

Reading of minutes of the previous meeting was dispensed with and the business session immediately opened.

Names of two new candidates for membership were read and forwarded to the society censor committee for investigation and approval.

It was noted that the biennial report of the Kent County Medical Society Corporation was currently due and the Society Secretary was directed to forward this to the office of the Secretary of State.

The guest speaker, Dr. Wade E. Bishop, visiting physician at Rhode Island Hospital and the outpatient thyroid clinic at Massachusetts General Hospital, was introduced and he gave an interesting talk on thyroid disease. Particular prominence was given thyrotoxicoses and its medical and surgical management. The thiouracil series of drugs and radio-active iodine were considered, the latter from diagnostic as well as therapeutic approach.

This discussion provoked considerable round table comment to everyone's profit.

Appreciation was extended Dr. Wade Bishop by Society President Dr. Jeannette Vidal, and the meeting brought to adjournment at 11:30 p.m.

Respectfully submitted,

FRANCIS D. LAMB, M.D.
Secretary

PAWTUCKET MEDICAL ASSOCIATION

A regular monthly meeting of the Pawtucket Medical Association was called to order by the President, Dr. Earl Mara, at 9:00 p.m., February 19, 1948, in the Nurses' Auditorium of Memorial Hospital.

The minutes of the previous meeting were accepted as read by the secretary.

The report of the Nominating Committee was given by its chairman, Dr. G. Raymond Fox, who presented the following slate for the coming year:

President: Earl J. Mara, M.D.
Vice President: John Gordon, M.D.
Treasurer: Laurence A. Senseman, M.D.
Secretary: Kieran W. Hennessey, M.D.

Delegates:
Earl J. Mara, M.D.
Charles L. Farrell, M.D.
Henry J. Hanley, M.D.
Robert T. Henry, M.D.

Standing Committee:
G. Raymond Fox, M.D.
Joseph H. Doll, M.D.
Armand A. Bertini, M.D.
Edward H. Trainor, M.D.
William N. Kalcounos, M.D.

Dr. Mara discussed the attendance at the medical meetings emphasizing that delegates must have representation when they vote. He suggested that every meeting should be a dinner meeting and that dues should be increased to make possible lectures by prominent men. The chair appointed Dr. Tetreault, Dr. Gaudet, and Dr. Kalcounos to formulate plans.

The speaker for the evening was Dr. G. Edward Crane whose topic was "Orthopedics and the General Practitioner." At the end of his remarks Dr. Crane answered a number of queries from the floor.

The meeting adjourned at 10:45 p.m.

Fourteen members attended.

Respectfully submitted,

K. WILLIAM HENNESSEY, M.D.
Secretary

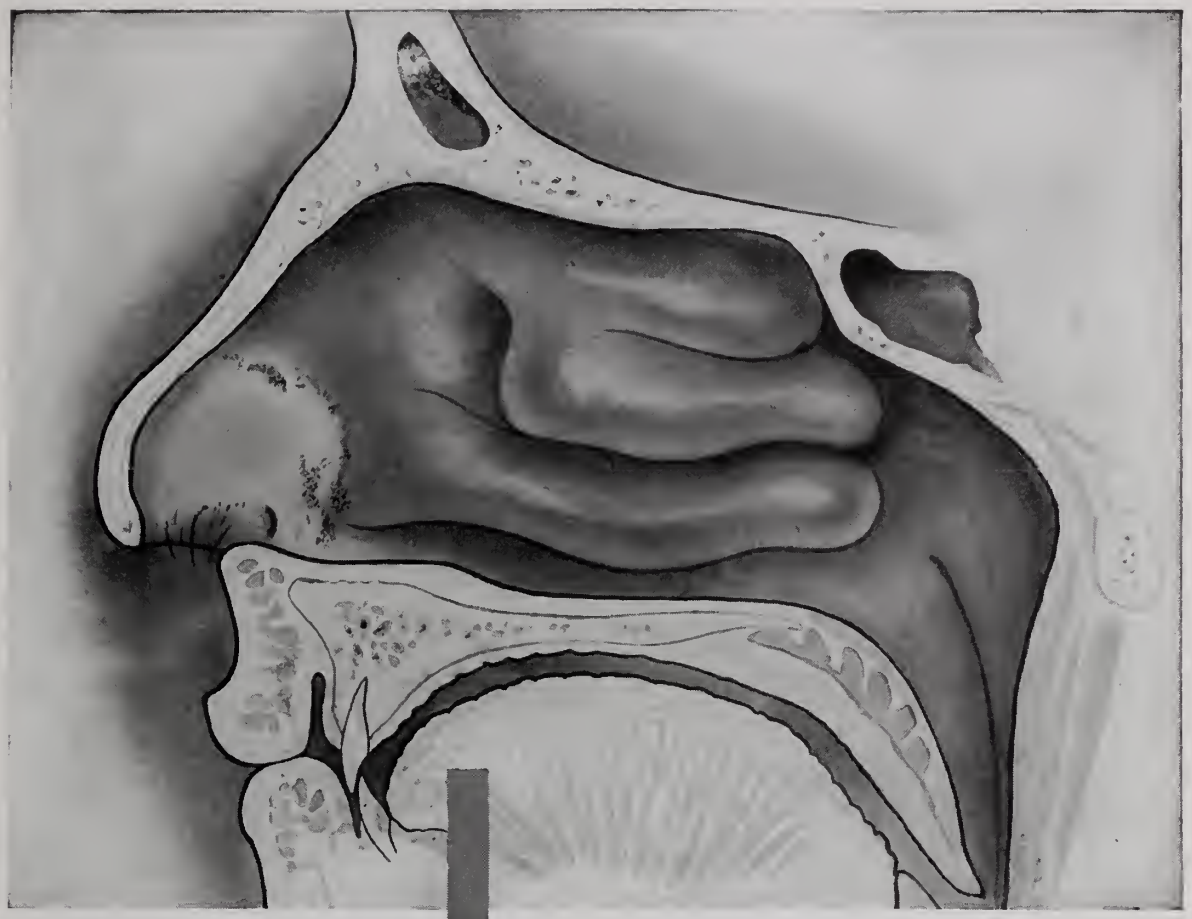
PROVIDENCE MEDICAL ASSOCIATION

A REGULAR MEETING of the Providence Medical Association was held at the medical library on Monday, March 1, 1948. The meeting was called to order by Dr. Philip Batchelder at 8:30 p.m.

The reading of the minutes of the previous meeting of the Association was omitted by consent of the members present.

The secretary reported that the secretary of the state medical society had requested members to fill

continued on page 264



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PROVIDENCE MEDICAL ASSOCIATION

continued from page 262

out the questionnaire enclosed with the February issue of the RHODE ISLAND MEDICAL JOURNAL relative to service on committees of the state medical society.

The president announced that the Miriam Hospital has inaugurated an annual oration to be known as the Dr. Isaac Gerber Oration and that the first oration will be delivered at the medical library on Wednesday, March 10, by Dr. Merrill C. Sosman, Director of the Department of Radiology at Peter Bent Brigham Hospital. He reported that an invitation was extended to all members of the Providence Medical Association to attend this lecture.

The President announced that the membership of the committees of the Association would be published in the March issue of the RHODE ISLAND MEDICAL JOURNAL, and that each man named to serve has been individually notified.

The secretary reported that at the recent meeting of the Executive Committee it was voted to recommend to the Association the election to active membership of:

(1) Dr. Edward Cardillo, a graduate of Classical High School, Rhode Island State College, and Tufts Medical School, and presently admitting physician at Rhode Island Hospital.

(2) Dr. Abraham Horvitz of 111 Waterman Street, Providence, a graduate of Classical High School, Brown University, and Columbia Medical School.

The motion was made, seconded and adopted that the nominees be elected to active membership in the Association.

Dr. Henry E. Utter presented the following resolution:

WHEREAS, on the occasion of the 100th anniversary of the founding of the Providence Medical Association, officially celebrated at Providence on Saturday, January 31, 1948, Dr. Reginald Fitz of Boston delivered the Centennial Oration, and

WHEREAS, this oration constitutes one of the finest historical presentations in the annals of medical history in New England, and,

WHEREAS, Dr. Reginald Fitz has honored the Association highly by his contribution to the success of its Centennial,

THEREFORE, BE IT RESOLVED, That this Association meeting in regular assembly express its sincere appreciation to Dr. Reginald Fitz for his notable address on occasion of the Centennial observance on January 31, 1948, by transmitting a copy of this resolution to him, and by spreading it also upon the official records of the Association.

The resolution was unanimously adopted.

Dr. Batchelder presented the first speaker of the evening, Dr. Aaron T. Beck, Former Assistant Resident in Pathology, Rhode Island Hospital, at present Assistant Resident in Neurology, Cushing General Hospital, Framingham, Massachusetts, who presented, "A Case of Prerenal Azotemia Resulting From Pyloric Stenosis, With Postoperative Follow-Up."

Dr. Beck defined axotemia as an accumulation of nitrogen in the blood. Uremia is the term given to the clinical picture. Axotemia can be produced by prolonged vomiting due to intestinal obstruction, diarrhea, cholera, coma, and Addison's crisis. He presented a case of duodenal obstruction who had several hospital admissions with high blood nitrogen and convulsions from which she recovered with intra venous saline. She was admitted a third time to the State Hospital in a stupeous condition from which she recovered with intra venous saline. Each time she became comatous her blood urea nitrogen would rise and she would become alert and clear with intra venous salt. Last admission was to the Rhode Island Hospital where it was thought that her azotejia was due to vomiting and dehydration. A daily residual of 1000 cc. was obtained. X-ray revealed a dilated stomach. Sub-

continued on page 266

OFFICE HOURS WEDNESDAY

In answer to a recent questionnaire sent out by the Providence Medical Association the following physicians have indicated that they will change their free afternoon from Wednesday to the day indicated after their name:

Richard S. Arlen, M.D.	*Thursday*
Joseph M. Badway, M.D.	*Saturday*
Alvah H. Barnes, M.D.	*Friday*
William J. Butler, M.D.	*Saturday*
Francis Corrigan, M.D.	*Monday*
Walter F. Fitzpatrick, Jr., M.D.	*Thursday*
Stanley Freedman, M.D.	*Thursday*
Carlotta N. Golini, M.D.	*Friday*
Herbert F. Hager, M.D.	*Friday*
James Hamilton, M.D.	*Monday*
John Langdon, M.D.	*Saturday*
William L. Leet, M.D.	*Thursday*
Henry Miller, M.D.	*Friday*
Barrito B. Mongillo, M.D.	*Thursday*
Samuel Pritzker, M.D.	*Saturday*
William Roberts, M.D.	*Thursday*
Bernard Sherman, M.D.	*Thursday*
Clara L. Smith, M.D.	*Thursday*



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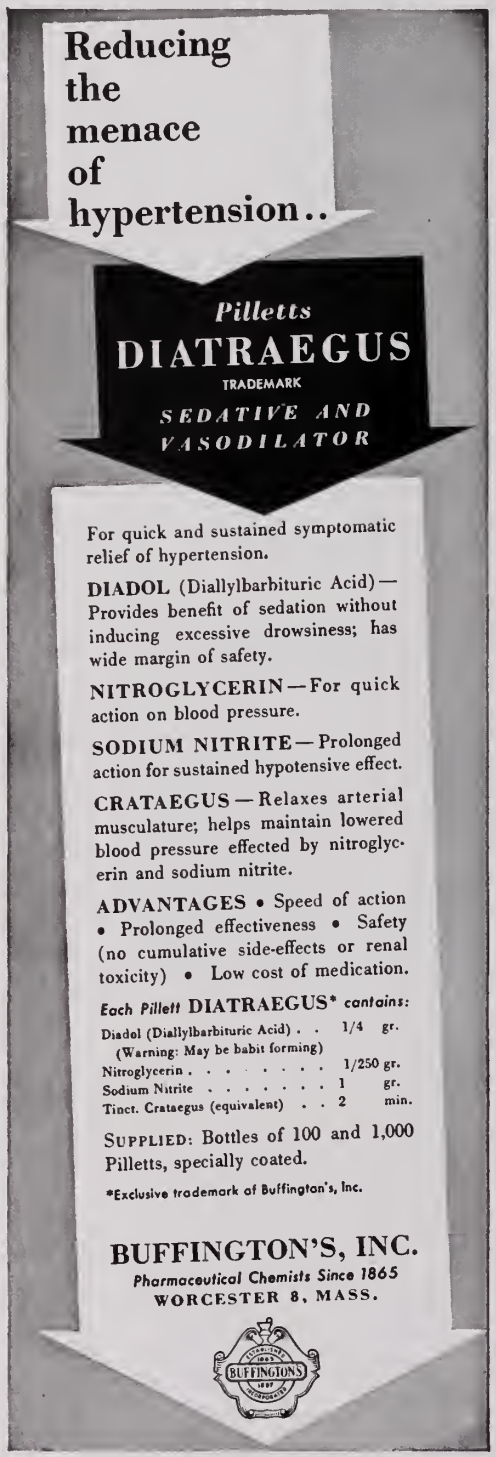


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PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	2.00 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.



PROVIDENCE MEDICAL ASSOCIATION

continued from page 264

total gastrectomy was done and a scarred ulcer in the region of the pylorus was found. Follow up shows gain in weights, no further symptoms, almost normal blood urea nitrogen, but still only fifty per cent normal renal function tests.

Dr. Batchelder reported that the Executive Committee had recently voted to invite from time to time representatives of some of the community agencies and societies contributing to the public welfare to attend the meetings of the Association and to give brief reports of their services to aid the public generally and the physicians in particular. He then called upon Miss Matty L. Beattie, executive secretary of the Rhode Island Children's Friend Society. Miss Beattie stated that the general subject of adoption of children is filled with confusion and misunderstanding. The tendency in all programs is to keep families together through welfare, etc. Children suffer when they are separated from their parents. The general policy is to give the mother time for her decision, usually six months. This also enables the pediatrician to determine whether the baby is normal. The Children's Friend Society needs lists of both Catholic and Protestant families, also different nationalities that can be studied to see if they are fit for adopting children.

The future happiness for the family and child is more assured in this manner.

The president introduced Dr. Charles Bradley, Superintendent of the Emma Pendleton Bradley Home, who presented the subject, "Behavior Difficulties of Children Who Suffered Anoxia at Birth or in Infancy."

Dr. Bradley noted that children who had suffered asphyxia in childhood showed certain quite definite characteristics. They had an unpredictable variability in mood; some days fine and some days terrible. The same reports come in from teachers, showing a hypermobility, greater motor activity, darting about and restlessness. Mothers say my child acts first and thinks afterward. This impulsiveness is another characteristic.

They have a short attention span. The parents say that for a few days they remember well, then they forget it all as if they never heard about it. They usually have difficulty with arithmetic in school.

These observations were made by a trained staff over a period of years.

18.7 per cent had pertussis up to three years.

42 per cent had asphyxia.

continued on page 268



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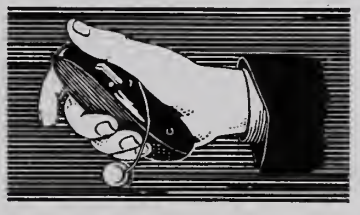
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PROVIDENCE

AMA MEETING IN JUNE

Physicians planning to attend the annual meeting of the American Medical Association to be held in Chicago from June 21 through the 25 should make hotel reservations immediately.

Train accommodations may be secured by communicating with the District Passenger Agent's office of the New York, New Haven and Hartford railroad, at Providence Union Station (DExter 5700). For the convenience of the members of the Society the executive office plans to have a representative of the railroad present during the two days of the annual meeting, May 12-13, to assist those desiring to plan railroad vacation trips in connection with their journey to the AMA sessions.

PROVIDENCE MEDICAL ASSOCIATION

concluded from page 266

A control group was used. Charts of behavior showed that the asphyxia group had these six traits one and one-half times as often as the control group. The per cent of patients who had at least five of these symptoms is highest in the infancy period one to four years.

He made a plea for prevention of natal asphyxia by prompt delivery and no sedatives and for prevention of pertussis by early immunization.

As a tribute to Dr. Bradley's many services to the Association which he now leaves to accept a professorship at the school of medicine at the University of Oregon, the president called for a rising vote of appreciation from the membership in adjourning the meeting.

The meeting adjourned at 10:15 p.m.

Attendance 97.

Respectfully submitted,
DANIEL V. TROPPOLI, M.D.
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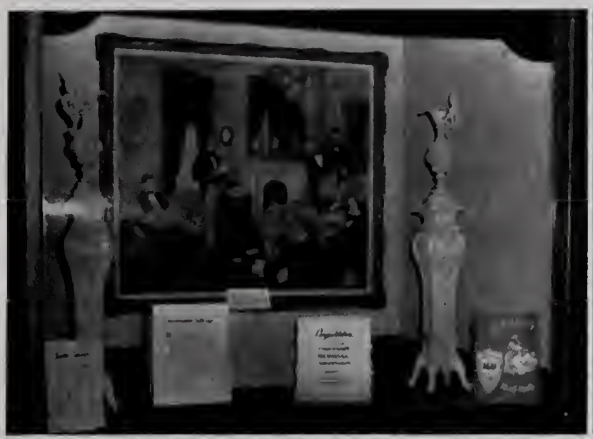
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Window displays in center of Providence during the Centennial Celebration of the Providence Medical Association featuring the Wyeth paintings *"Pioneers of American Medicine"*. 1, Outlet Company; 2, Blanding and Blanding; 3, Hospital Trust Bank; 4, Boston Store; 5, The Shepard Store; 6, Providence Gas Company; 7, U. S. Army Recruiting Office (The C. V. Chapin portrait and medal collection owned by the R. I. Medical Society).

WOMAN'S AUXILIARY

Proposed Revisions to the Constitution and By-Laws of the Woman's Auxiliary to the Rhode Island Medical Society

The Committee on the revision of the By-Laws has submitted suggested revisions as noted below which have been approved by the Board of Directors. In accordance with the By-Laws the publication of these proposed revisions is presented in this issue of the JOURNAL. The membership will be requested to vote on the changes at the annual convention to be held on May 12, 1948.

PROPOSED AMENDMENTS TO THE CONSTITUTION

Article VI—General Officers

Section 1—The general officers of the Auxiliary shall be the President, the Vice President, the President-Elect, the Secretary and the Treasurer.

(a) Not more than three of these officers shall be from one Medical Society district.

Section 2—The President, the Vice President, the President-Elect, the Secretary and the Treasurer shall be elected annually by the Convention and shall assume office at the close of the Convention at which they were elected and shall serve until the corresponding period of one year hence or until their successors are elected and installed, provided, however, that the President shall not serve for a longer period than one year except in case of an emergency so determined by the Advisory Council of this Auxiliary.

Article VII—Board of Directors

Section 1—The Board of Directors consists of the President, the Vice President, the President-Elect, the Secretary and Treasurer and a Director elected annually from each of the Medical Society Districts in the State, to serve for a term of one year.

PROPOSED AMENDMENTS TO THE BY-LAWS

Chapter III—Duties of General Officers

Section 3—In the absence of the President from a Convention or if by reason of death or refusal or failure to serve or qualify or other reason, the Presidency becomes vacant, the Vice President assumes the functions of the office for the time being or serves the unexpired portion of the term, according to the necessities of the case. (a) The President-Elect shall assume the duties of the Vice President in case of the latters absence, shall attend all board meetings for one year and shall be nominated for President at the next election.

Chapter IV—Committees and Their Duties.

Section 10

(a) The Nominating committee chairman shall meet with the President at least two months prior to the Annual meeting.

(b) The Nominating Committee shall present its proposed slate of Officers to the Executive Board meeting preceding the Convention.

ANNUAL MEETING

of the

WOMAN'S AUXILIARY

MAY 12, 1948

At the Plantations Club, Providence

Luncheon at 12:30 p.m.

Speaker — Mrs. Luther H. Kice, President-Elect of the Woman's Auxiliary to the American Medical Association

Business Meeting.

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SOME COMMON MISCONCEPTIONS REGARDING DERMATOLOGY

Laymen complain that the medical profession uses bombastic and altogether unnecessary large words in their writings. We in the profession are prone to criticize the dermatologists for their unusually complex and difficult nomenclature. Therefore, we call attention to the arguments of nationally outstanding dermatologists who feel that they refute this criticism and who at the same time make a plea for more general knowledge of their specialty amongst the profession.

—The Editors

Dr. Marion B. Sulzberger, director of the New York Skin and Cancer Unit, the major center of dermatological training in the world, and Dr. Rudolf L. Baer, writing in the 1947 Year Book of Dermatology and Syphilology, call attention to the inadequacies of the training received by the student in dermatology in our medical schools compared with European universities having large hospitals devoted entirely to the study of the skin.

Such insufficiency is evident when one thinks that Harvard Medical School offers 5 lectures-hours and a few clinical demonstrations to make the student prepared to cope with the dermatological problems of his practice. Our large hospitals offer, perhaps, more clinical teaching to the intern than the university to the student, but the intern, in his 2 years rotating service has a great deal to do in the other branches of medicine, generally considered more important, and is completely disinterested in dermatology.

It is strange that dermatology should be considered as playing a minor role in medicine when one considers, as Sulzberger and Baer say, that "affections of the skin account for a large proportion of all human diseases, representing 10 to 15 per cent of the everyday practice of the general practitioner. A group causing over 10 per cent of all disabilities in the United States armed forces, in some theatres of war responsible for over 60 per cent of all cases of military disability. In civilian medicine at least 60 to 80 per cent of compensable occupational diseases are diseases of the skin. Furthermore, cancer of the skin is more common than cancer of any other organ.

Do dermatologists use unusually strange names for skin diseases?

Sulzberger and Baer do not find dermatologic nomenclature significantly different from the rest of medicine using such terms as: retinitis pigmentosa, acute, serous, localized nonsuppurative leptomeningitis, atypical verrucous mural endocarditis, Rendu-Osler-Weber hereditary hemorrhagic telangectasia, Duchenne-Aran muscular atrophy and Landouzy-Dejerine fascioscapulohumeral atrophy.

Dermatological terms are unfamiliar to the general medical ear and eye, whereas those of most other branches of medicine are not. In most medical schools the student from the beginning becomes acquainted with such terms as Duchenne-Erb paralysis, Hand-Schüller-Christian disease, arthritis deformans, subacute bacterial endocarditis and others. During 5 or 6 years these terms become the familiar objects of his world. Not so, however with dermatophytosis, dermatophytids, pityriasis rosea; lichen planus, nummular eczema, all diseases which he is likely to encounter in practice hundreds of times more often than Hand-Schüller-Christian disease or Duchenne-Erb paralysis. The dermatological terms (and concepts) are suddenly thrust upon the student for an hour or two a week during a few weeks of his overcrowded third or fourth year and his overburdened mind and vocabulary tend to reject them as useless and senseless.

The medical student and the young physician are given exhaustive and painstaking instruction in the therapy of diseases of most organs other than the skin. Sometime toward the end of the medical school curriculum a pitifully small number of dermatologic therapeutic agents are suddenly thrust upon the student, usually without adequate explanation. He considers it a highly specialized unnecessary addition to his burden.

Are results of treatment less satisfactory in skin diseases than in diseases of other organs?

Sulzberger and Baer remark that many laymen, many scientists and even some workers in medicine have forgotten the many diseases against which physicians are still helpless. The common cold, most headaches, most types of heart trouble, hypertension, the arthritides, infantile paralysis, the leukemias, many cancers, most forms of kidney diseases and nervous and mental diseases are still clothed in mystery and inaccessible to cure by any

known medical therapy. However, colleagues often evidence considerable surprise that dermatologists possess no specific and effective therapy against psoriasis, lichen planus, etc.

As far as ignorance of causes and lack of scientific, specific therapy are concerned, dermatology has its psoriasis and lichen planus to parallel the athropaties, its chronic eczemas to parallel the hypertensive states and its many self-limited or recurrent but mild diseases to parallel the common cold or the common headache.

Causes of misconceptions are the high expectation of cure on the part of both physician and patient where skin diseases are concerned just because skin diseases are conspicuously discernible and accessible, and the anguish of the human ego attacked by personal disfigurement or tortured by maddening itching.

The patient with heart, kidney disease or hypertension does not, as a rule, expect a cure and does not blame physician or medicine when cure is not forthcoming. But the patient with chronic eczema or psoriasis is shocked at dermatologic ignorance when he is told that the cause of his trouble is unknown.

Sulzberger and Baer remind of the contribution of dermatology to the progress of medicine with the study of cancer and carcinogenesis stemmed from the recognition of arsenical, tar, chimney-sweeps', dyes cancers, the infections (syphilis and gonorrhea), the many laboratory methods developed by dermatologists, allergy and immunology, serology, tuberculosis and tuberculids, sarcoidosis ("discovered" now by the internist), the precancerous, senile and presenile degenerative lesions of the skin, the pioneer studies leading to the recent discoveries on histamines and cutaneous vessels, etc. In this era of psychosomatic medicine, they recall the works of Bonjour and Block on the "suggestion treatment" of warts, reporting the first—and perhaps the only—unequivocal and scientifically established series of cures of a definite somatic disease (a tumor and a virus infection) by purely psychic influences.

Sulzberger and Baer conclude that most of the present costly misconceptions concerning dermatology will be remedied when undergraduate and graduate medical schools provide more adequate time and facilities for the teaching of the specialty and as soon as the essential clinic, hospital, laboratory and research facilities and the proper and due shares of available funds are apportioned to the departments of dermatology in medical schools and in hospitals.



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PROVIDENCE MEDICAL ASSOCIATION 1848

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BOOK REVIEW

ADVANCES IN MILITARY MEDICINE
Two volumes—900 pages—Illustrated. Little, Brown and Company, Boston, 1948. $12.50.

This valuable book is a report on some of the work done by American Investigators working under the sponsorship of the Committee on Medical Research of the Office of Scientific Research and Development during World War II. The last of the work was published in 1946. It contains a list of the members of the Scientific Personnel of the Committee on Medical Research of the Office of Scientific Research and Development including Members, Staff, Consultants and Advisers. There is a bibliography of all the publications made under the contracts of this Committee which fills seventy-six pages, also a list of the contracts which fills fifty-two pages. There is an adequate index. This book is a necessity for any working library so that a researcher may find out what was accomplished in any given line. The subject matter covered ranges all the way from pure science to pure utility. The title is unfortunate as the use of the term "Military Medicine" will steer many doctors away from it. Reading the volumes tends to advance the thesis that there is no such thing as "Military Medicine". It is all fundamentally medicine with its application to the given need which usually varies only in degree between civilian and military. These volumes show what may be accomplished under the spur of war with practically unlimited funds and personnel and, for part of it, unlimited clinical material.

LUCIUS C. KINGMAN, M.D.

MAKE RESERVATIONS PROMPTLY FOR THE ANNUAL DINNER MAY 12

DR. REGINALD FITZ CITED

WHEREAS, on the occasion of the 100th anniversary of the founding of the Providence Medical Association, officially celebrated at Providence on Saturday, January 31, 1948, Dr. Reginald Fitz of Boston delivered the Centennial Oration, and

WHEREAS, this oration constitutes one of the finest historical presentations in the annals of medical history in New England, and,

WHEREAS, Dr. Reginald Fitz has honored the Association highly by his contribution to the success of its Centennial,

THEREFORE, BE IT RESOLVED, That this Association meeting in regular assembly express its sincere appreciation to Dr. Reginald Fitz for his notable address on occasion of the Centennial observance on January 31, 1948, by transmitting a copy of this resolution to him, and by spreading it also upon the official records of the Association.

. . . Adopted by the Providence Medical Association in regular meeting, at Providence, March 1, 1948

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INDEX OF ADVERTISERS

	PAGE
Abbott Laboratories	259
Alkalol Company	268, 271
E. P. Anthony, Inc.	275
Ar-Ex Cosmetics, Inc.	268
Arlington Chemical Company	253
Ayerst, McKenna & Harrison	223
Bayview Convalescent Home	261
Blanding & Blanding	234
Borden Company	231
J. E. Brennan & Company	267
George A. Breon and Company	228
Joseph Brown Company	271
Buffington's, Inc.	266
Butterfield Drug Stores	267
Camel	222
S. H. Camp Company	225
Ciba Pharmaceutical Products, Inc.	221
Coca-Cola	271
Curran and Burton	268
Davies, Rose & Company	Inside Front Cover
Edgewood School	232
J. E. Hanger, Inc.	261
Hillcrest, Inc.	271
Langlais Health Institute	271
Eli Lilly & Company	Insert between 234-235
McCaffrey, Inc.	261
Mead Johnson & Company	Back Cover
Medical Milk Commission	228
Merck & Company	224
A. B. Munroe Dairy	267
Mutual Benefit Health and Accident Association	230
Neland Pharmaceutical, Inc.	261
Parke, Davis & Company	229, 255
Physicians Directory	276, 277
Rhode Island Limb Company	268
Schering Corporation	257
G. D. Searle & Company	251
Smith-Holden, Inc.	226
Tilden-Thurber	267
U. S. Vitamin Corporation	233
Wander Company	265
White Rock Bottling Company of Rhode Island	261
Winthrop-Stearns, Inc.	263


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Volume XXXI, No. 5

Contents Page 283



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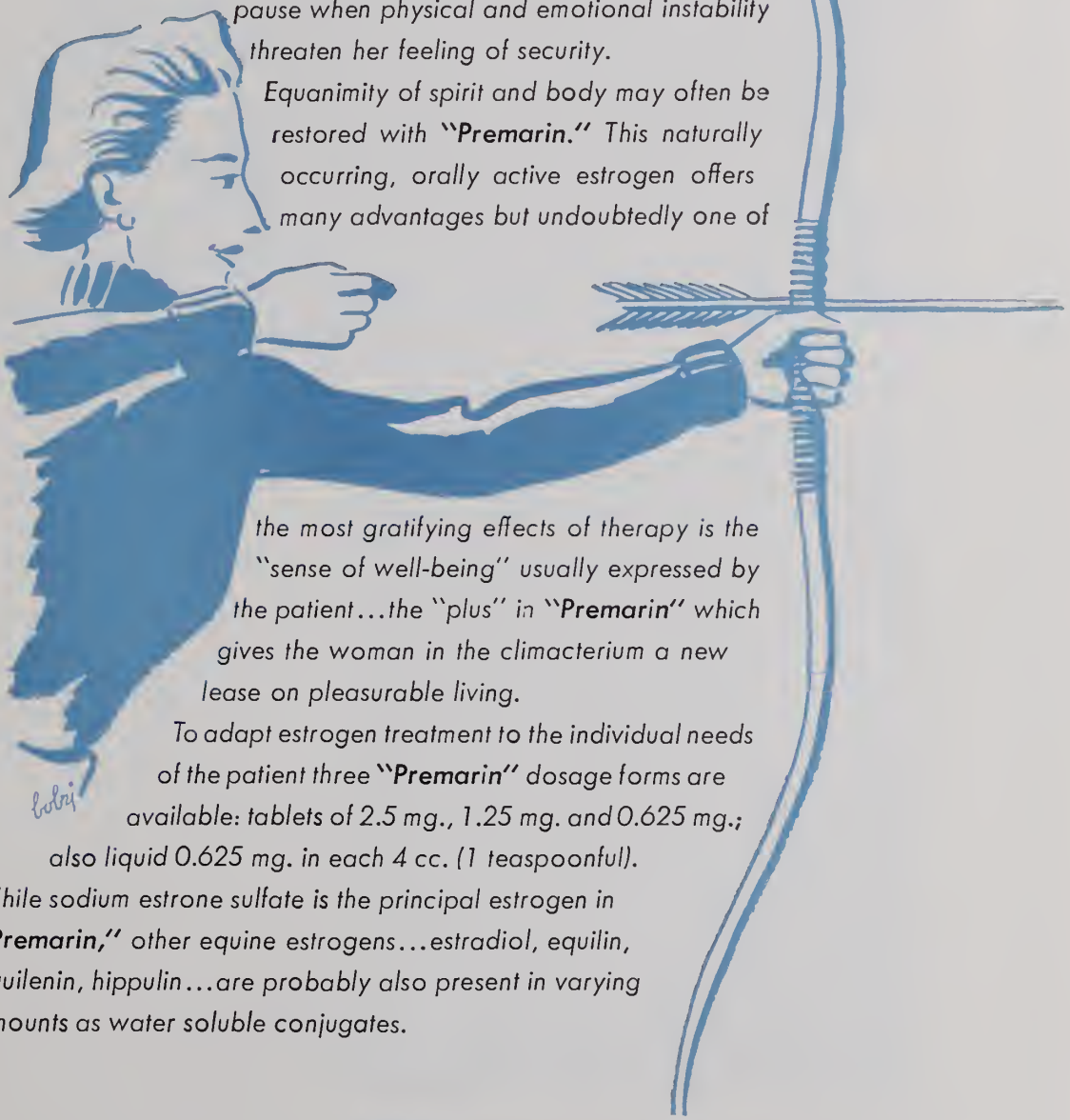
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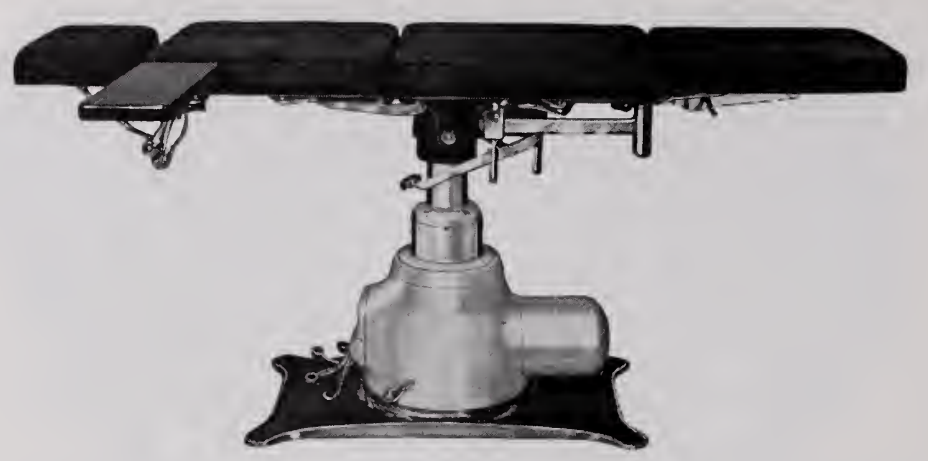
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TABLE OF CONTENTS

PAGE

Blood and Plasma in Surgical Emergencies, *F. A. Simeone,* M.D. 291
Fractures of the Shaft of the Tibia, *Robert T. Henry,* M.D. 299
Subacute Bacterial Endocarditis, Report of a Case, *Jacob Greenstein,* M.D. 302
The Rhode Island Plan, Questions and Answers on Surgical Program 312
Participating Physicians, The Rhode Island Plan 318
Message of the President of the Society, *Joseph C. O'Connell,* M.D. 309
The Doctor Isaac Gerber Oration 324

EDITORIALS

Crawford Allen Hospital 306
Psychosomatic Shift 307
"Pediatrics" 307
The Chapin Medal 307

DEPARTMENTS

District Medical Society Meetings 326
Postgraduate Medical Education in Rhode Island 332
Medical Library Notes (Book Reviews) 338
Health in Providence in 1947 345
Officers and Elected Committees, 1948-49, Rhode Island Medical Society 284

MISCELLANEOUS

Index of Advertisers 348

Photographs . . .
Joseph C. O'Connell, M.D. 308
Officers of the Society 310, 311
Isaac Gerber, M.D. 325

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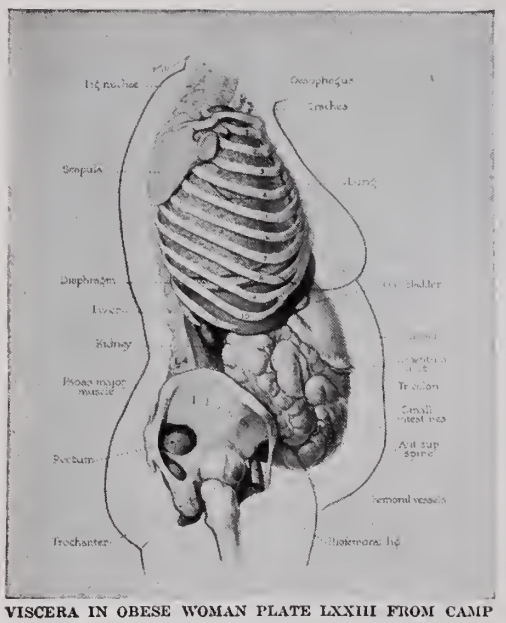
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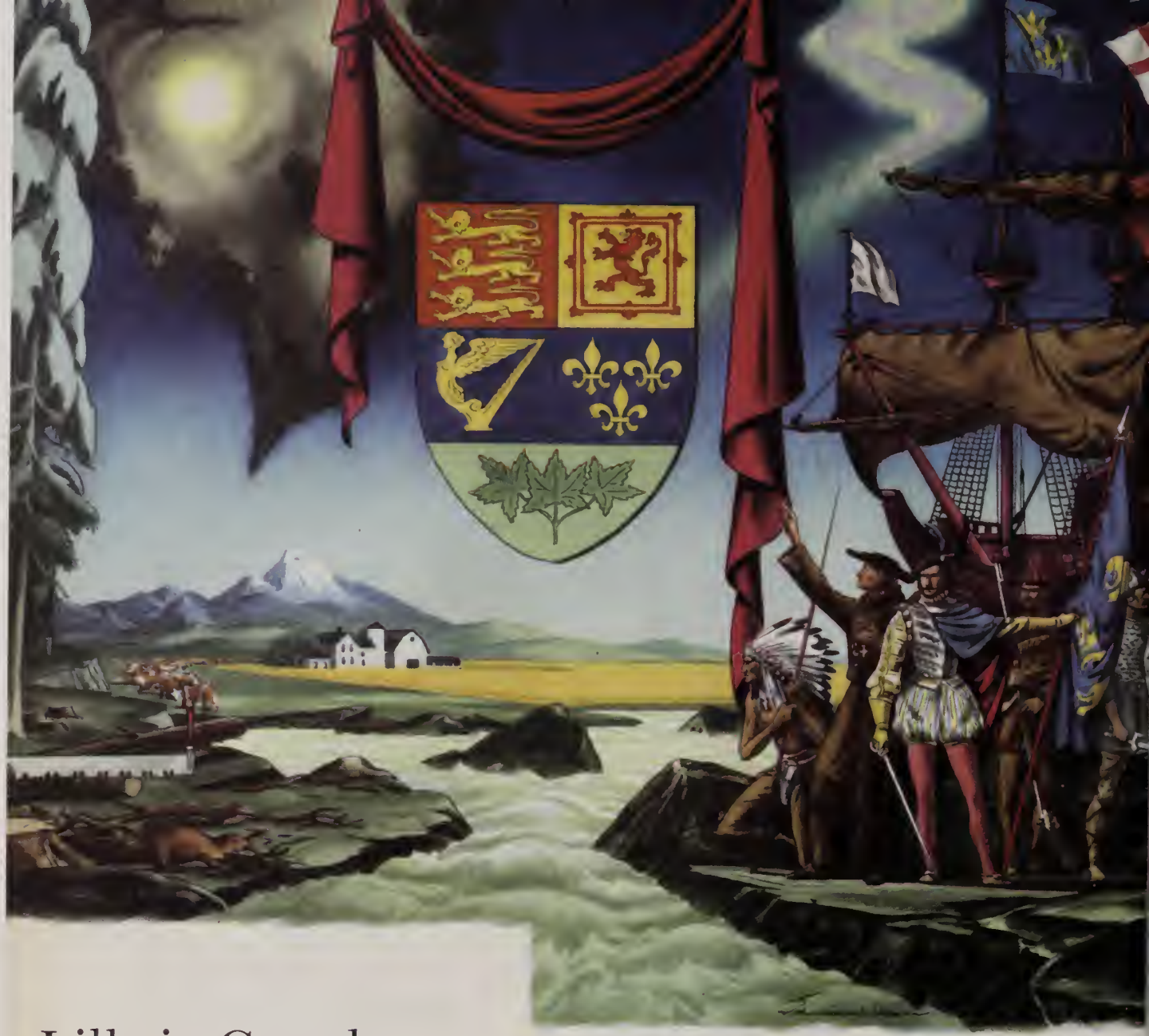


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BLOOD AND PLASMA IN SURGICAL EMERGENCIES*

F. A. SIMEONE, M.D.

The Author. *Fiorindo A. Simeone, M.D., of Boston, Mass. Assistant Professor of Surgery, Harvard Medical School, and Assistant Surgeon, Massachusetts General Hospital.*

THE USE of blood and plasma has received extraordinary impetus in recent years, largely as the result of experiences in World War II and other catastrophies. During the War between the States, blood transfusion was used in only two cases.[1] One was a soldier from Massachusetts wounded on June 16, 1864. His convalescence was complicated by secondary hemorrhage, and he was given a transfusion of 2 ounces of blood obtained from the temporal artery of a healthy German. "Immediately after the injection a marked difference was noticed in the patient's pulse, which became stronger and firmer." The second transfusion was given to a soldier from Illinois wounded at Kenesaw Mountain on June 26, 1864. Again because of complications during convalescence, he was transfused slowly with 16 ounces of blood taken from a healthy man. The patient improved but died eventually, 9 days later, from secondary hemorrhage and dysentery. By contrast with this grand total of 18 ounces of blood used in 1864, it is interesting to note that during a one-year period toward the close of World War II, at least 70,000 pints of blood and an approximately equal number of units of plasma were used. Was the use of this large amount of blood and plasma merely the manifestation of a passing "fad" or was it truly justified? To approach an answer to this question, let us consider the indications for the administration of blood and plasma in typical surgical emergencies, namely, traumatic shock and severe burns:

*Presented at the John F. Kenney Annual Clinic of the Memorial Hospital Internes' Alumni Association, at Pawtucket, R. I., on October 29, 1947.

1. The oligemia of traumatic shock. During the past three decades, a classic monograph, three books, and a number of reviews have been written on traumatic shock and allied conditions. They bear witness to the importance of the problem and to the unsettled nature of the controversies about it. To consider in detail the various theories regarding the nature of traumatic shock or a classification of the different causes for the clinical state known as "shock" would take us too far afield. In brief, we should like to interpret the phenomena observed in shock as brought about primarily by a discrepancy between the capacity of the arterial tree and the volume of blood available to fill it effectively. Obviously, this discrepancy can be the effect of a number of different causes. Nevertheless, the basic fault, an absolute or relative oligemia, is common to all of them. In traumatic shock, our contention is that the discrepancy is brought about by actual loss of whole blood from the circulation either into serous-lined cavities, into the tissues, or onto the ground. Some of the evidence for this point of view is as follows:

a. Wounded men can lose a large amount of blood and still survive. Figure 1 illustrates the average amounts of blood lost by battle casualties from wounds in different locations. It should be emphasized that these are average figures and do not represent extremes. In general, patients with extremity wounds, and particularly those with compound fractures, lose more blood than do others (Figure 2).

The clinical manifestations of patients in shock are closely correlated with the amounts of blood that they have lost. Casualties in shock can be classified as to degree of severity by evaluating the changes that occur in the blood pressure, the pulse, the circulation of the skin, thirst, and the state of the sensorium.[2] The severity of the patient's re-

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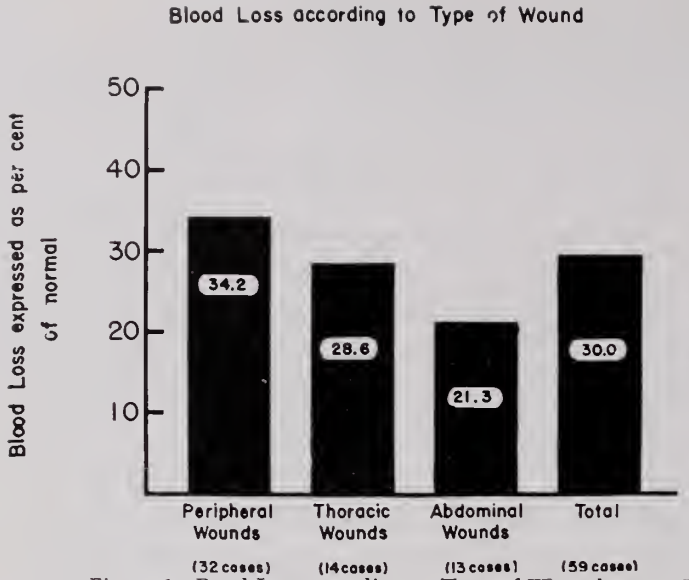


Figure 1. Bood Loss according to Type of Wound

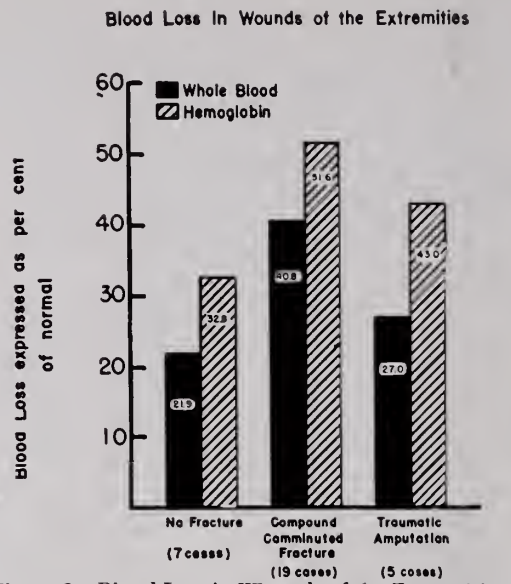


Figure 2. Blood Loss in Wounds of the Extremities

action to trauma, and therefore the severity of shock, can then be evaluated by taking a composite reckoning of all the observations. While at first glance it would appear that such a classification is neither reasonable nor practical, on second thought it does appear logical and did prove very useful for interpreting physiologic and biochemical changes that occur in the severely wounded. It must be emphasized, however, that the severity of shock cannot be estimated on the basis of any one single observation, but rather on the basis of a composite of all the clinical observations taken together.

b. The degree of shock, as evaluated clinically, is closely related to the amount of blood lost. In spite of the fact that the degree of shock among the seriously wounded was estimated purely on clinical grounds, without reference to laboratory data, the amounts of blood lost by the wounded correlated very closely with the severity of shock based on the clinical manifestations (Figure 3). It is reasonable

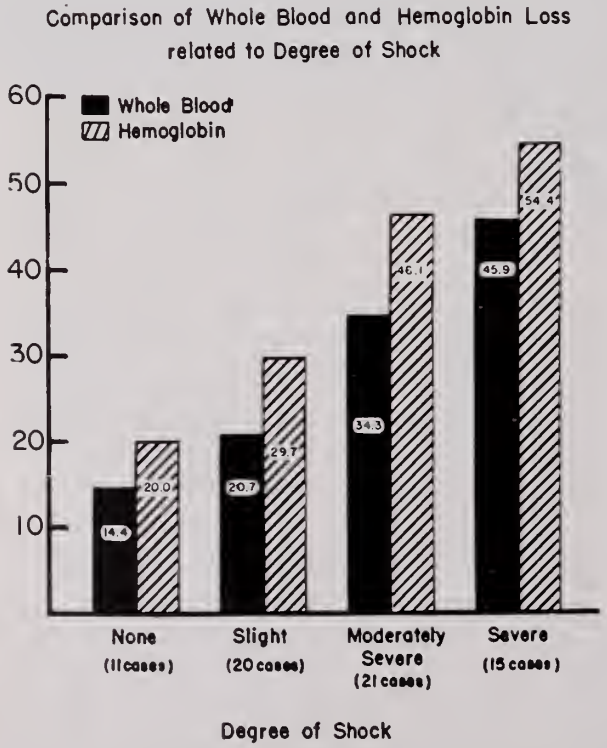


Figure 3. Comparison of Whole Blood and Hemoglobin Loss related to Degree of Shock

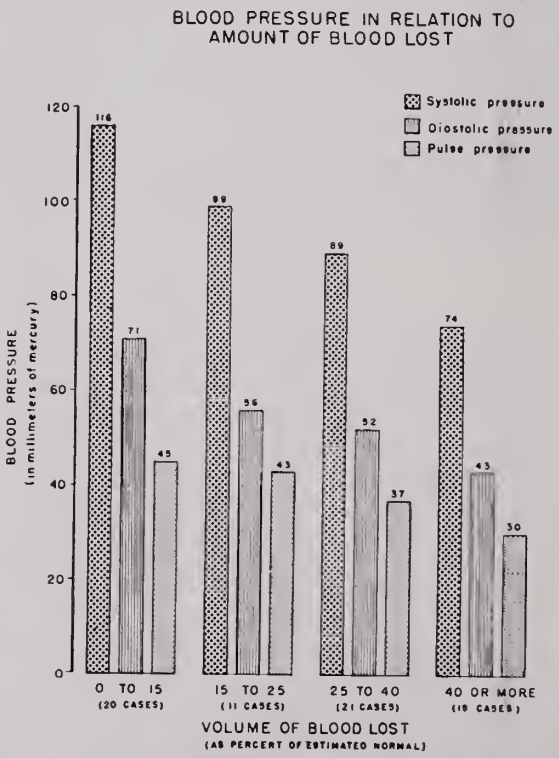


Figure 4. Blood Pressure in Relation to Amount of Blood Lost

to conclude that these manifestations are the results of blood loss and it should be possible to correct them by blood replacement.

c. The blood pressure changes are closely related to amounts of blood lost. Unlike the changes in pulse rate which showed no significant correlation with different amounts of blood lost, the systolic, diastolic and pulse pressures showed a progressive drop with increasing amounts of blood lost (Figure 4). A similar correlation was found between decreases in the systolic, diastolic and pulse pressures and increasing degrees of shock as evaluated clinically with reference to other criteria than the blood pressures alone. A falling blood pressure, then, an excellent guide for degree of shock, is primarily a function of blood loss in traumatic shock.

d. The magnitudes of the physiologic changes in traumatic shock are closely related to the amounts of blood lost. The function of the kidney is depressed in shock and there is some indication that the degree of depression increases with increasing severity of shock. Recovery of renal function is slow. Liver function is depressed, too, but in this instance a correlation with degree of shock or with amount of blood lost could not be made.[2] Hyperglycemia, thought to be related to activation of the sympathico-adrenal system, was correlated both with the degree of shock and with the amount of blood lost (Figure 5).

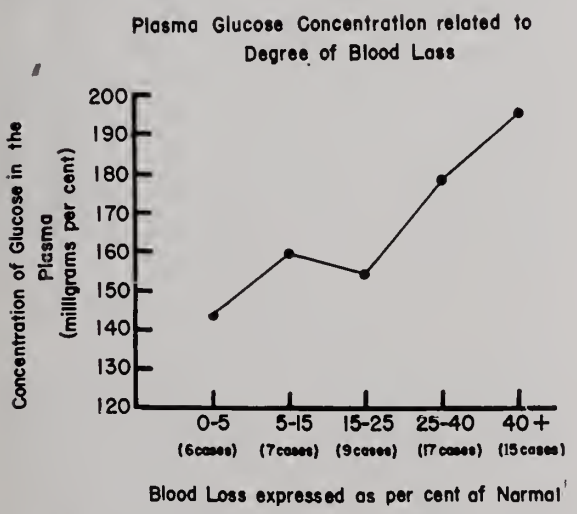


Figure 5. Plasma Glucose Concentration related to Degree of Blood Loss

These data lend strong support to the concept that traumatic shock is the consequence of a loss of blood from the circulation and that the severity of the phenomena observed is in direct proportion with the amount of blood lost.

2. The need for blood replacement in traumatic shock. When blood is lost from the circulation, the organization for physiologic homeostasis is brought into play. The small vessels are contracted to accommodate the shrunken blood volume, the spleen contracts and expells a small volume of blood, however insignificant, into the general circulation, and the heart accelerates to make the most of what little blood reaches it. In addition, fluid is withdrawn from the tissues and into the circulation in an attempt to restore the circulating blood volume. Hemodilution results. Hemoconcentration does occur in the crush syndrome and in severe burns, but these are special situations. If after cessation of blood loss these physiologic mechanisms are sufficient to ensure an adequate circulation through vital organs, the patient survives and restores his plasma and blood cell volumes during the ensuing days. Otherwise, the vital organs fail because of lack of circulation through them, and the patient dies. Obviously, the latter eventuality can be prevented by replacing the lost blood entirely or at least in amounts sufficient to maintain an adequate circulation. Logically, whole blood should be used, for that is the fluid which is lost.

Another point should be made to emphasize the need for an aggressive policy of whole blood replacement in traumatic shock. It has already been pointed out that as the natural reaction to acute oligemia, fluid is withdrawn from the tissues into the circulation. (This fluid does not contain red cells but does contain protein. Hence the hematocrit value falls [hemodilution], but the concentration of plasma proteins is affected to a much less extent.) Figure 6 indicates that after a certain amount of blood has been lost from the circulation, the concentration of magnesium, an intracellular cation, rises in the plasma, suggesting that at that point the intracellular compartment is tapped for

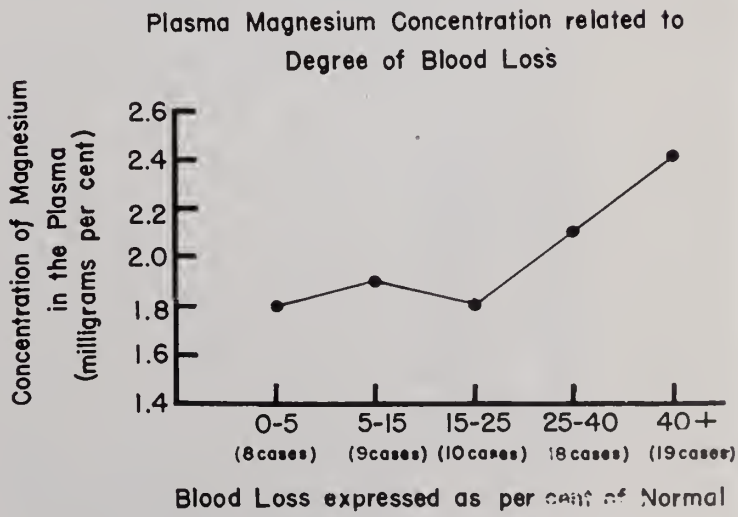


Figure 6. Plasma Magnesium Concentration related to Degree of Blood Loss

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fluid for the circulation. If this withdrawal of intracellular fluid continues, it is logical to assume that serious functional, and eventually structural, derangements might be produced in vital organs. A study of the severely wounded suggested that such is the case (Figures 7 and 8). The incidence of serious impairment of renal function was related to the degree of shock and to the amount of blood the casualties had lost.

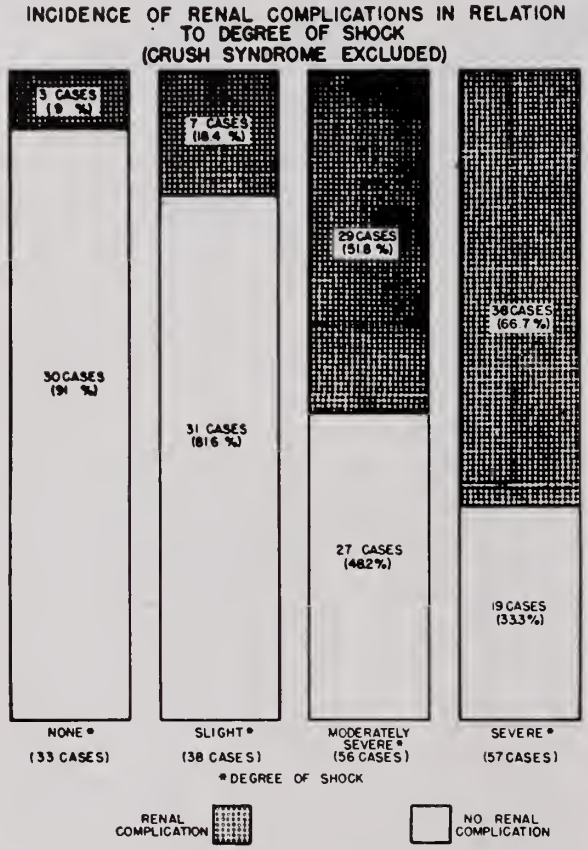


Figure 7. Incidence of Renal Complications in Relation to Degree of Shock

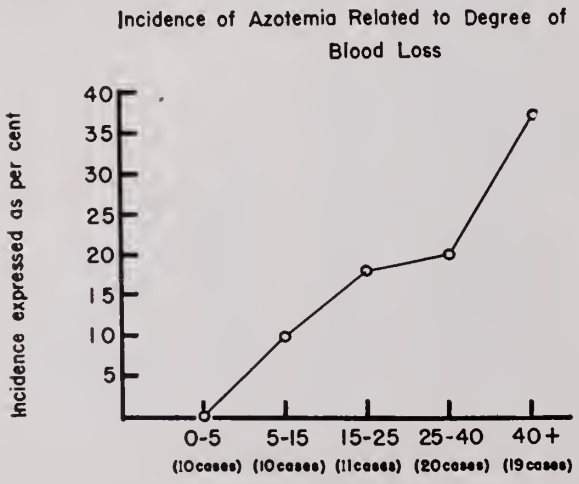


Figure 8. Incidence of Azotemia Related to Degree of Blood Loss

It is logical to ask, "How much of the lost blood is it necessary to replace?" Complex organisms, such as man, operate on an economy of abundance. We possess more blood than we actually need. A liter of blood can be dispensed with and its loss is scarcely noticed. While theoretically it would be ideal to restore the overabundance by complete blood replacement, it is not absolutely necessary and certainly not advisable to delay operation in order to accomplish that end.[3] Pre-operative blood replacement can be considered adequate when the blood pressure is over 80 millimeters of mercury systolic, the pulse rate is dropping, the skin is warming, and circulation is returning in it. Blood replacement is continued during the operation, which itself may be considered, a part of resuscitation.[3]

When a patient in shock fails to respond to the administration of blood, something is wrong. Some have thrown up their hands and have attributed the phenomenon to the onset of a state of "irreversible shock". Whether such a state exists is debatable and is really a matter of definition. What is certain is that the condition must be rare, for when the cause of failure to respond to blood replacement is sought energetically, the cause is usually found to be continued hidden bleeding, continued peritoneal irritation from perforation of the gastro-intestinal tract, bronchial obstruction with atelectasis, fat embolism, clostridial myositis, and even such conditions as cerebral malaria.

3. Blood versus plasma in traumatic shock. A consideration of the evidence just presented leaves little question about the need for blood to correct the oligemia of traumatic shock. Crystalloid solutions were demonstrated to be ineffective as early as World War I. Solutions of gum acacia, pectin and gelatin have decided drawbacks and are of little value. Solutions of free hemoglobin have been tested, but they are dangerous in the presence of shock. Plasma has proved to be very useful as an expedient for it can correct the deficiency in the volume of circulating blood, the correction is lasting, and the condition of the patient is improved. There are dangers in its use, however, because while the patient may appear to have been brought out of shock, if transfused with large volumes of plasma alone, the uncorrected deficiency in circulating hemoglobin makes the patient a very poor risk for a surgical procedure or even for moving from a stretcher to an operating table. Plasma is an incomplete substitute for whole blood and should be used in traumatic shock only while whole blood is not available. Availability is plasma's great advantage. The same might be said of concentrated albumin. The ideal fluid for correcting the oligemia of traumatic shock is whole blood since that is what has been lost from the circulation.

4. The oligemia of severe burns. The shock encountered among patients who have incurred severe second and third degree burns has been classified into a category all its own: "burn shock". Actually, the fundamental feature is an oligemia, as it is in traumatic shock, but here the oligemia is a consequence not of whole blood loss, but primarily of plasma loss. Plasma leaves the circulation into blisters, into the dressings, and particularly into the surrounding tissues. Attempts have been made to prevent at least a part of this loss into the tissues by the application of pressure dressings. Pressure, however, is often difficult to apply and its efficacy has not been clearly determined. Cope and Moore[4] have studied the changes in the distribution of body water in the burned patient and have applied the findings to the formulation of a rational schema for fluid therapy in the management of severe burns. The discussion below is based on the data from their study.

a. *Calculation of composition and amount of fluid lost from the circulation in patients with severe burns.* Except for a lower concentration of protein (approximately 4.0 grams per cent in burns), the composition of the fluid lost in burns approaches that of normal plasma. As one would expect, the amount of fluid lost into the tissues and from the surface of a severe burn varies with its extent. Burns involving less than 10% of the body surface are of little moment as far as fluid replacement is concerned. The requirements can usually be satisfied by an oral intake. With more extensive burns, proper management depends upon a careful estimate of the fluid lost from the surface of the wound and into the surrounding tissues. Measurements made from the open surfaces of burned areas suggest that in the course of 48 hours, two to six liters of fluid may be lost (cf. table 1). The composition

ESTIMATED LOSS OF FLUID FROM BURN SURFACE

Surface Area Involved (As Per Cent of Total)	Volume of Fluid Lost (Cubic Centimeters in 48 Hours)
25 - 35	1000
35 - 60	2000
60 and over	3000

Table 1. Estimated Loss of Fluid From Burn Surface

of this fluid is comparable to that of plasma except for the lower protein content. The fluid lost into the tissues can be considered as an expansion of the interstitial compartment of body water and can be measured fairly accurately by the dilution of thiocyanate or of radioactive sodium injected intravenously. Such measurements have indicated that a surprisingly large volume of plasma-like fluid is transferred from the intravascular plasma compartment into the interstitial compartment. Again, as might be expected, the amount of this transfer of fluid can, within limits, be considered proportional to the extent of the burn. If the extent of the burn is less than 50% of the surface area of the body (table 2), the volume of fluid displaced may be calculated on the basis of a transfer out of circulation of 75 c.c. of plasma and 75 c.c. of physiologic saline in 48 hours for each per cent of surface area burned. For more extensive burns ("total burns"), the fluid lost into the extracellular space in 48 hours may be computed as 10% of the body weight. Besides this, fluid is lost from the burn surface as indicated in table 1. If the former is replaced as plasma the latter may be replaced as physiologic salt solution.

TABLE FOR ESTIMATION OF EXTENT OF SURFACE BURNED AREA
(After Berkow)

Region	Per Cent of Body Surface Involved
Head	6
Upper extremities:	
Both arms and forearms	13.5
Both hands	4.5
Total	18
Trunk:	
Anterior surface	20
Posterior surface	18
Total	38
Lower extremities:	
Both thighs	19
Both legs	13.6
Both feet	6.3
Total	38.9

Table 2. Table for Estimation of Extent of Surface Area Burned

In addition to the replacement necessitated directly by the burn, the normal fluid requirements of the individual, had he had no burn at all, must be kept in mind. For the urinary output, 1500 c.c. of fluid should be allowed daily and half of it may be in the form of physiologic saline. For the evaporation from the lungs and for both insensible and sensible fluid losses from the skin, an additional 1500 c.c. should be administered daily; this in the form of dextrose in distilled water.

b. The time relationship of the loss of fluid from the circulation. Careful studies of the loss of fluid from the circulation have shown that the loss is very rapid at first, but the rate decreases until by the end of 48 hours very little, if any, further loss is expected. For this reason, it is best to calculate the fluid requirement of a seriously burned patient on a 48 hour basis. The calculations are based upon the extent of surface area involved (table 3) for

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ANTICIPATED FLUID REQUIREMENT
IN SEVERE BURNS
(According to Proportion of Surface Area Burned)

Kind of Fluid	Expected Loss from Burn (10% of Surface Area) in 48 Hours	Normal Loss from Body (Adult) in 48 Hours		Total to Be Replaced in 48 Hours
		Kidneys	Other	
Water	.....	1500	3000	4500
Physiologic Electrolyte Fluid	1500*	1500	.....	3000
Plasma	1500*	.....	.....	1500
TOTAL	3000	3000	3000	9000

*Calculated for a 10% surface area burn on basis of 75 cc. for one per cent of body surface burned per day.

Table 3. Anticipated Fluid Requirement in Severe Burns (According to Proportion of Surface Area Burned)

burns of less than 50% of the surface area of the body: More extensive burns are better considered "total burns" in which the maximum loss possible is expected and the replacement is calculated according to body weight (table 4). The rate of replacement should parallel the expected rate of loss, so that 50% of the calculated fluid for replacement is administered in the first 12 hours, 75% of the total by the end of 24 hours, 87% by the end of 36 hours, and the total by 48 hours (Figure 9).

Fluid for expansion of the interstitial fluid compartment may no longer be required after the first 48 hours. As a matter of fact, beyond that time fluid is absorbed from the tissues and there is danger of hydraemic plethora, which, particularly in the elderly, may lead to fatal pulmonary edema. Parenteral fluid therapy should be limited, therefore, by the end of the second day, and the adequacy of therapy checked as described below.

ANTICIPATED FLUID REQUIREMENT
IN SEVERE BURNS
(According to Expected Expansion of Interstitial Fluid Compartment in "Total Burns")

Kind of Fluid	Expected Loss from Burn in 48 Hours (Cubic Centimeters)	Normal Loss from Body (Adult) in 48 Hours (Cubic Centimeters)		Total to Be Replaced in 48 Hours (Cubic Centimeters)
		Kidneys	Other	
Water	.....	1500	3000	4500
Physiologic Electrolyte Fluid	2000**	1500	.....	3500
Plasma	7500*	.....	.....	7500
TOTAL	9500	3000	3000	15500

*Calculated for a 75 kgm. man, on basis of 10% of body weight.

**Calculated on basis of burn involving 50% of surface area.

Table 4. Anticipated Fluid Requirement in Severe Burns (According to Expected Expansion of Interstitial Fluid Compartment in "Total Burns")

Diuresis during this phase normally rids the body of the excess water calculated to be necessary to prevent oligemia and shock during the first 48 hours.

It will be seen that the amounts of fluid recommended are surprisingly large in extensive burns, but necessarily so. It is often necessary to administer the fluid through more than one vein in order to keep up with the requirements. Whenever possible, fluid should be administered by mouth. The oral intake can be subtracted from the calculated fluid requirement, but not until effective absorption from the gastro-intestinal tract has been demonstrated by an effect upon the urinary output.

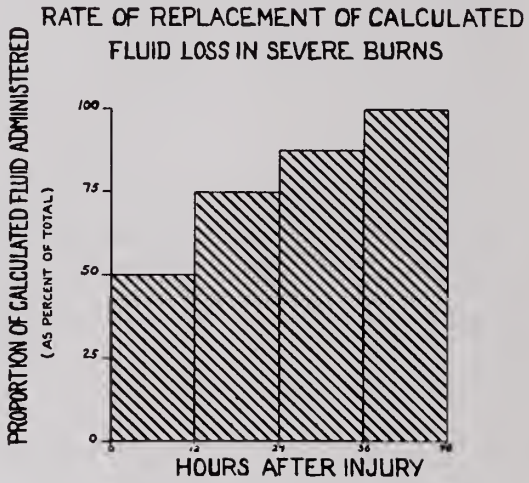


Figure 9. Rate of Replacement of Calculated Fluid Loss in Severe Burns

c. Evidence for adequacy of fluid replacement. It is important to emphasize, that the estimates suggested for fluid replacement in severe burns are, at best, close approximations. They have been based on laboratory data and have withstood the test of clinical trial. However, since variations do occur in the fluid requirements from one case to the next it is important to have some check on the therapy. An excellent check on the adequacy of fluid therapy is the hourly measurement and charting of the urinary output through an inlying catheter in the bladder.[4] Such a chart is an excellent indicator of the adequacy of fluid replacement. If the urinary output is 40 to 80 c.c. per hour, the fluid intake may be considered adequate. If the output is greater than this, fluid administration may be curtailed. A progressive drop in the urinary output below this level and continued for 2 or 3 successive hours, warns the observer of impending oliguria and anuria.

d. The treatment of oliguria and anuria in burns. In the kind of patient under discussion, two causes for oliguria and anuria have to be considered: first, the possibility that there is an insufficient amount

of body water available for the kidneys to excrete and second, that the kidneys have been damaged ("lower nephron nephrosis") and are unable to elaborate and excrete urine. It is all-important to distinguish between these possibilities because the treatment for one is the opposite of the treatment for the other.

The "water-tolerance" test[4] was devised for this purpose. It is done very simply and without danger. Within a period of 30 or 40 minutes a liter of 5 per cent dextrose in distilled water is given intravenously and the effect of this upon the hourly urinary-output chart is noted. If the oliguria or anuria is the consequence of oligemia, or lack of available body water, there will be a prompt diuresis; if the failure of the urinary output is due to renal damage, however, there will be no diuresis in response to the rapid injection of the test solution. The test fluid need not be dextrose in distilled water. Review of what fluid the patient has already received may suggest that the test should be done with plasma (hemoconcentration and low plasma protein), or if the specific gravity and the chloride concentration of the urine are low, it may be preferable to inject dextrose in physiologic saline. As a rule, however, dextrose in distilled water is the most useful.

If the "water tolerance test" indicates dehydration, the rate of fluid replacement must be increased. With the basic requirements in mind, the absolute composition of the fluid administered can be varied according to the hematocrit and plasma protein values and to the specific gravity of the urine. If the test suggests that the oliguria is not the result of lack of available fluid for the kidneys, but rather the result of renal damage ("lower nephron nephrosis"), it is essential to curtail the administration of fluid. After the expected expansion of the interstitial fluid space is satisfied, no more fluid should be administered than to meet the losses that normally take place through evaporation and any other losses through abnormal channels (vomiting, diarrhea, exudation from extensive open wounds). Attempts to induce a diuresis in such patients by forcing fluids intravenously have led inevitably to death from pulmonary edema before the patient had a chance to die from azotemia. Diuretics have been ineffective.

c. The anemia of burns. Patients who have incurred deep extensive burns almost always develop a hypochromic anemia. The causes for this anemia are not entirely clear, but recent investigations have thrown light on the question (cf. Moore, Peacock, Blakely and Cope).[5] The acute hemolysis and the immediate loss of red cells that occurs thereby in deep thermal burns is well recognized and is attributed to an increased red cell fragility,[6] but this is a relatively minor matter, as far as the anemia is concerned, and does not account for the progressive anemia that these patients develop during the convalescence.

During the first week of convalescence, as already mentioned, much of the extravasated fluid is absorbed from the tissues and re-enters the circulation. This, in itself, leads to a lowering of the hemocrit value and gives the false impression of an anemia, a "pseudo-anemia", for the lowered hematocrit in this case does not indicate a decrease in the total red cell volume in the circulation. Treatment of this "pseudo-anemia" with whole blood could overload the circulation and cause fatal pulmonary edema. The diagnosis of this peculiar situation is made by surgical perspicacity or by the actual determination of circulating red cell volume by laboratory techniques.

Beyond this period of resorption of interstitial fluid, however, there is a true anemia which may be attributed to a combination of factors: chronic loss of small amounts of blood from large granulating wounds, depression of the bone marrow as the result of infection or other causes, and interference with the absorption and/or the proper metabolism and utilization of iron. Repeated whole blood transfusions are needed to correct this anemia and their use is essential to promote the healing of wounds in these patients and to decrease the frightful morbidity usually associated with serious burns.

COMMENTS

It is impossible to overemphasize the value of blood and plasma in surgical emergencies of which traumatic shock and severe burns have been taken as examples. Their use has undoubtedly saved countless lives during World War II and there is no doubt that they will continue to be most valuable adjuncts to surgical practice in the future. It is important to point out, however, that there is hardly any therapeutic agent, which is not attended by certain drawbacks. In the case of blood, tragedies have occurred from technical errors in the matching of blood, or when properly matched for the intended patient, there have been rare cases in which the blood has been given to a patient for whom it was not intended and of the wrong group. Fortunately, such complications are very rare, and they are mentioned only to emphasize the need for constant vigilance, with checks and re-checks, to be as certain as is humanly possible that the patient is receiving blood which has been accurately matched and which is intended for him. Particularly in women, and in all patients in whom a prolonged convalescence is foreseen, the matter of the Rh antigens must be carefully considered. There is danger in being too complacent of "universal

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donor" blood. Such blood may contain a sufficiently high anti-A titer to cause serious reactions in an A recipient. The ideal universal donor blood is Rh-negative and has had its anti-A and anti-B agglutinins neutralized (Whitebsky's specific substances). To use such blood indiscriminately, however, is neither necessary nor practical. Type-specific blood with Rh reaction matching that of the patient is the safest and most practical blood to use in individual cases.

A word should be said about auto-transfusion. This is a useful procedure and the necessary apparatus should be readily available in every operating room. The blood shed in the peritoneal cavity can be easily aspirated and re-injected into the patient. Blood for this purpose has been successfully collected from the vagina in massive metrorrhagia. It has been used even when contaminated with intestinal contents, though not by choice. In general, it should not be used when pus is present or when the blood is already clotted.

There is danger in administering too much citrate with blood transfusions in patients who show evidences of liver damage and impairment of renal function (as in toxemia of pregnancy). In such instances, if more than 2 liters of blood are administered, impairment of the clotting mechanism may occur as the result of the injected citrate which is not metabolized promptly, as it is normally.

There are certain dangers in the use of plasma. Especially on using plasma that has been pooled from a large number of donors, the incidence of homologous serum jaundice should be kept in mind as a definite hazard to weigh against the possible benefits from plasma administration. The indications for the use of plasma should be limited to the replacement of lost blood while waiting for whole blood, and to instances where there has been obvious loss of plasma (burns). To use plasma for replenishing serum protein, or for fulfilling the daily protein requirements of a patient is hazardous, impractical, and ineffective. To administer 120 grams of protein would require 2 liters of plasma, and there are better ways to accomplish that end. Neither blood nor plasma should be used when the benefit to be derived therefrom does not outweigh the calculated hazard from their use.

SUMMARY

1. Blood and plasma are indispensable agents for restoring the circulating blood volume when this is dangerously decreased in surgical emergencies.

2. In traumatic shock, whole blood is lost from the circulation and whole blood should be used for replacement.

3. In burns, plasma is lost from the circulation and plasma is indicated for restoration of the circulating blood volume during the period of expansion of the extra-cellular fluid space.

4. The necessity of a careful check on fluid replacement in severe burns is emphasized and the use of the "water tolerance test" is described.

5. Whole blood is necessary to treat the anemia which is encountered both early and late during convalescence from a severe burn.

6. It is emphasized that the administration of blood and plasma is not without its hazards and whereas these are life-saving agents they must be used with great care and good judgment.

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AN INVITATION IS EXTENDED

All members of the Society are invited to attend the meeting of the St. Joseph's Hospital Staff at the Nurses' Auditorium on Tuesday, May 25, at 9 p.m. when Dr. Edward G. Waters of New York will present a paper on "Common Ovarian Tumors as Factors in Sterility and Pregnancy."

Dr. Waters is assistant clinical professor of obstetrics and gynecology at Columbia, and he is also division chief of obstetrics at the Margaret Hague Maternity Hospital in Jersey City.

Physicians planning to attend this lecture should inform the Record Office at the hospital in order that arrangements may be made for the serving of the collation following the meeting.

FRACTURES OF THE SHAFT OF THE TIBIA*

Types and Treatment (Bone Grafts and Non-Union)

ROBERT T. HENRY, M.D., F.A.C.S.

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WE, of the Orthopedic service, desire to present for your approval a discussion of one of the problems that confronts us in our daily ward service, namely, the treatment of fractures of the shaft of the leg bones, particularly of the tibial shaft with special reference to the phase of delayed and non union with remedial bone grafting.

In this highly industrialized community we have an opportunity to treat a great many fractures of the lower extremities. We consider fractures of the shafts of leg bones to be important for the following reasons:

1. The large number of compound and infected fractures,
2. The tendency of oblique and spiral fractures to slip,
3. The disability attendant on poor alignment or rotation of the fragments which disturbs the normal line of weight bearing and makes for painful residuals,
4. The frequency of slow union due primarily in most cases to the poor blood supply of the bone at this level,
5. The possibility of non union if slow union is not recognized or if immobilization is not sufficiently prolonged.

Fractures of the shaft of the Fibula usually cause no functional incapacity as the shaft of this bone bearns no weight and serves mainly for muscular attachments.

Transverse fractures of the tibial shaft in which there is sufficient end bearing surfaces to allow for satisfactory alignment can usually be immediately manipulated, reduced and immobilized in plaster. This method of immediate reduction and casting has likewise proven advantageous in treating some spiral and oblique graft fractures. If the alignment has not been completely satisfactory we have occasionally been able to correct it by wedging the cast.

*Presented at the John F. Kenney Annual Clinic of The Memorial Hospital Internes' Alumni Association, at Pawtucket, R. I., on October 29, 1947.

Most spiral and oblique fractures occur as the result of torsion and it is not unusual to see the fragments tapering off to a sharp peak. The Gastrocnemius and Soleus muscles play a great part in distracting and displacing the fragments since the Soleus is attached below the knee and the Gastrocnemius is attached to the lower end of the Femur posteriorly. Most oblique fractures tend to displace upward. They respond well to treatment by skeletal traction with the pin or wire placed through the Os Calcis. The pin or wire may, if desired, be passed through the Tibia and Fibula above the ankle joint but the Os Calcis method is easier of application and in our opinion more satisfactory. Suspension of the leg in a Thomas splint facilitates traction and makes for the comfort of the patient. Traction is usually continued until the fracture is in satisfactory alignment by X-ray examination and clinically "sticky" enough to allow for further immobilization in plaster without danger of slipping.

The treatment of slowly uniting fractures of the tibial shaft is a much discussed problem. It is often most difficult to draw any sharp line of distinction at the point at which slow or delayed union actually becomes non union. We have no hard and fast rule at this hospital. Each case must be decided on individual merit and circumstance. When, from clinical and X-ray evidence the decision is made that the fracture is not healing properly, we do not hesitate to operate the fracture and have successfully used bone grafts, usually of the inlay type, to accelerate callus formation as well as to internally splint and immobilize the fracture.

The repair of fractures and the rate of union is determined to a great degree by the vitality and vascularity of the fragments. If the blood supply is free, union is fairly rapid. If the blood supply is cut off or impaired, union may show varying degrees of slowness. The blood supply of normal bone is derived not only from a main vessel but from many other vessels entering the cortex from the capsule, ligament and tendon attachments. The ends of bones show many vascular openings which explains why fractures of the bony extremities heal fairly rapidly. This is true of fractures in the shoulder area, wrist joint, knee joint and ankle

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region. On the contrary shafts of bones may be completely devoid of vascular foramina. This is especially true of the shaft of the Tibia which depends mainly for its blood supply on the nutrient artery. Fracture of the tibial shaft may cut off this sole-source of blood supply so that the vitality and viability of the lower fragment is impaired. Sometimes the distal fragment becomes almost exsanguinated and this impoverishment contributes greatly to slow union and non union. If the distal fragment becomes avascular and inert it is thereby unable to take part in the process of repair. This type of dense dead bone can often be demonstrated by X-Ray. It takes a long time for the upper living fragment to promote tissue growth to invade and replace the devitalized lower fragment. However, the dictates of the calendar should not be accepted as evidence of non union or slow union. A delay of a few weeks or months does not necessarily mean that the fracture will ultimately fail to unite.

Theoretically at least we must consider three stages during the healing process when slow or delayed union can be evaluated.

1. If the fracture line is still visible without undue separation of the fragments, if there is no cavitation of the opposing surfaces, no decalcification and no sclerosis, union is said to be slow. At this stage the fracture is not considered as an ununited fracture and it still may unite if it is immobilized long enough.
2. If by disturbing the traction or by changing of casts or other causes of motion causes the fracture line to become widened to the point of cavitation and the area becomes fuzzy and ill defined without recalcification or sclerosis, repair is not yet complete. At this stage the gap between the fragments is filled with granulation tissue not scar tissue. This is usually accepted as evidence of delayed union and the fracture must be further immobilized until the gap becomes recalcified and solid union takes place, which may require many months.
3. When the gap between the fragments is only partially filled, the margins well defined and the fracture surface relatively smooth and actual sclerosis has occurred, then non union is fairly well established and the third stage in the slow union, delayed union, non union triad has been ultimately reached. At this point the fragments are held by thick scar tissue and a false joint often develops within the cicatrix. It then becomes necessary to remove the scar tissue and dead bone and reconstruct the conditions of a fresh fracture if union is to be obtained. We feel that this procedure is best accomplished by bone grafting because in cutting a bed for the graft the dead and sclerosed bone is effectively removed. Mere open reduction and/or plating is not adequate treatment, a bone graft is required. It not only stimulates the growth of new bone but it also provides excellent internal fixation.

Often fractures of the tibial shaft may be adequately and accurately reduced but they show little bony union after immobilization for months. Most fractures elsewhere which exhibit signs of slow or delayed union will usually eventually unite if immobilized for the necessary period and held long enough. But the length of time consumed in tibial fractures, especially in this industrial country where the time element and the economic situation are major factors, together with the unfairness in handicapping a patient, particularly an elderly one, to the long months of inactivity required for prolonged immobilization makes internal fixation preferable. Therefore, a bone grafting operation may be done in the early months as a time saver. This procedure has become less hazardous due to developments in chemotherapy and antibiotics.

It should be emphasized that plating of itself will not accelerate bony union. An autogenous living graft is preferable for the stimulation of laying down of new bone. We know from histological studies that the graft eventually undergoes erosion and is invaded by granulation tissue and ultimately is entirely replaced by new bone. Consequently, if a living graft is capable of this stimulation of the laying down of new bone in addition to providing an adequate method of internally fixing the fracture, we feel that such operative methods justify themselves. Bone grafted fractures usually heal well and unite solidly.

In the remaining time at our disposal we would like to offer some evidence of our clinical efforts and demonstrate by X-Ray films some of the points discussed in this paper.

DISCUSSION

JOHN H. GORDON, M.D., *Member, Visiting Staff, The Memorial Hospital*

WE WOULD now like to present cases with x-ray films illustrating some of the points that Dr. Henry has brought out in his paper.

Case No. 1. G.S. No. 83238

This fifty-seven year old white male was admitted to the hospital December 10, 1946. While

at work a bale of wool fell on his right lower leg and he suffered an oblique comminuted fracture of the lower third of the right tibia with an associated fracture of the fibula. The admission x-ray films show the fracture with posterior angulation and little if any over riding. He was treated by manipulation and application of a plaster cast from toes to groin. X-rays taken December 13, 1946 show the position after manipulation with marked posterior and lateral angulation. It was felt that wedging of the cast might correct this angulation and on December 15, 1946 the procedure was carried out. X-rays taken the following day now show the fragments to be in satisfactory position and alignment. January 12, 1947 x-rays were taken which showed the fragments to have retained their former position and on that day he was discharged from the hospital walking with crutches. The last x-rays taken April 9, 1947 show the fractures to be healed. He was then walking without a limp and had no symptoms with reference to his right leg.

Case No. 2. WG. No. 79980

The next set of x-ray films to be shown are those of a twenty-eight year old white male who was admitted to the hospital October 14, 1945 following an automobile accident. He had a compound fracture of the left tibia through the middle third with a fractured fibula at a slightly higher level. The admission x-rays show the fracture with slight lateral displacement of the distal tibial fragment. An open reduction was done and the tibial fragments were held by a chromic catgut suture through drill holes. A plaster cast from toes to groin was then applied. The next x-rays shown were taken October 31, 1945. The cast had been wedged to correct some anterior angulation. The position and alignment was now considered satisfactory. This position was maintained in plaster casts. On June 3, 1946 the x-ray shown was taken. There is no evidence of callus formation at the site of the tibial fracture. Clinically there was no evidence of union and it was decided to do a bone grafting operation. This was done July 10, 1946. The procedure used was the sliding bone graft and the next x-rays show the graft in place and the fragments of the tibia to be in good alignment. These were taken July 15, 1946. The leg was kept in plaster until January, 1947 when by x-ray and clinically he had union. The last x-rays taken June 9, 1947 show bony union through the site of fracture.

Case No. 3. A.B. No. 79488

These x-ray films are of a thirty-nine year old white male who was admitted to the hospital June 14, 1946. He tripped over a lift while at work and fell injuring his right lower leg. The admission diagnosis was a compound fracture of the right tibia, middle third and a fracture of the right fibula. The admission x-rays show the medial displacement of the distal tibial fragment and the slightly oblique nature of the fracture. Because of the marked swelling of the leg this case was treated by Kirschner wire traction. The wire being placed through the os calcis and the leg held in a Thomas splint. The second x-rays taken June 24, 1946 show the fragments pulled down to length. There is still slight medial displacement of the distal fragment. The traction was continued and the next x-rays, taken August 9, 1946 show no evidence of callus formation. The fracture was then eight weeks old and it was felt that union would more surely be obtained if a bone grafting operation were done. On August 14, 1946 a sliding bone graft operation was carried out. At operation muscle tissue was found between the fragments. The next x-rays were taken September 25, 1946 and show the bone graft in place and the fragments in good position and alignment. Plaster fixation was maintained until union was obtained. The last x-rays taken July 11, 1947 show the fracture to be healed in excellent position and alignment.

Case No. 4. J.M. No. 76940

The next films are those of a forty-eight year old white male who was admitted to the hospital January 4, 1946. He had been struck by an automobile and had a compound fracture of the left tibia, lower third and a fractured fibula. The admission x-rays show lateral displacement of the distal tibial fragment with slight overriding. An open reduction was done followed by a plaster cast from toes to groin. The next x-rays taken January 5, 1946 show posterior displacement of the distal fragment. This position was considered satisfactory. On February 26, 1946 the cast was bivalved and x-rays were taken with the plaster removed. These x-rays show no evidence of callus formation. Clinically there was no evidence of union. It was decided that a bone grafting operation should be done in order to stimulate callus formation and also to improve the position. Kirschner wire traction was applied to attempt to overcome the shortening. No definite gain was made and on March 27, 1946 an open reduction with a sliding bone graft was done. The next x-rays, taken April 4, 1946, show the bone graft in place crossing the fracture line. The shortening has been corrected. The leg was held in a plaster cast from toes to groin until union was obtained. The last x-rays were taken March 4, 1947 and show bony union across the fracture site.

Case No. 5. E.G. No. 84424

The last set of films to be shown are those of a thirty-four year old man who slipped and fell injuring his right lower leg. He was admitted to the hospital February 15, 1947 with an oblique fracture of the tibia four inches above the ankle and a frac-

continued on page 316

SUBACUTE BACTERIAL ENDOCARDITIS*

Report of a Case Treated Successfully with Penicillin

The Author. *Jacob Greenstein, M.D., of Providence. Chief, Medical Service, The Memorial Hospital, Pawtucket, R. I.*

BEFORE the advent of the "Sulfonamides", the prognosis in Subacute Bacterial Endocarditis was practically hopeless. Folowing the use of these newer chemotherapeutic agents, there were some reports of clinical cures, but in the majority of instances these proved to be only temporary remissions with ultimately fatal outcomes. With the use of Penicillin, however, the outlook in this disease has become much more hopeful and a clinical cure can be expected in a large percentage of cases, especially when they are due to Penicillin sensitive strains of streptococcus viridans, if treated with adequate dosages for a sufficiently long period of time.

The following is a report of a case of Subacute Bacterial Endocarditis due to streptococcus viridans, twenty-eight months after successful treatment with Penicillin.

(Miss A.D.) a 27 year old dietitian's helper was admitted to this hospital on December 13, 1944 complaining of chills, fever, general malaise, and aching finger tips, of three weeks duration.

The patient had been in fairly good health most of her life and except for having known that she had a heart murmur since early childhood, which gave her no trouble, she had had no previous illnesses, accidents or operations. She did not recall having had Rheumatic Fever and had had only occasional sore throats.

(Present illness)—Approximately three weeks before admission, she began to have chills, fever, general malaise, and what she described as painful "plugs" in her finger tips. She was treated at home with 1 gram of "Sulfa" every four hours but her chills, fever, and general malaise persisted and she was transferred to the hospital for further observation.

On admission the physical examination revealed a well developed, fairly well nourished white female, extremely nervous and apprehensive, who appeared only moderately ill. Temperature—102.4 degrees, Pulse — 150, Respirations — 30, Blood pressure — 120/80.

The only positive findings were a slightly reddened throat, some "splinter hemorrhages" in the finger tips, and a grade II systolic murmur over the mitral area. The heart was not enlarged, the sounds were of good quality, and the rhythm was regular. Electrocardiographic findings were within normal limits. The lungs were clear and resonant with vesicular breathing throughout.

Laboratory findings were—
R.B.C.—4,900,000
Hgb.—11.5 gms.
W.B.C.—13,000
Differential—89% Polys. 11% Lymphs.
Blood urea nitrogen—11.2 mg. per 100 c.c.
Blood sugar—82 mgs. per 100 c.c.
Urine—negative
Wassermann—negative
Blood cultures taken on the day of admission and five days later were positive for streptococcus viridans.

The diagnosis made was Rheumatic Heart Disease, Mitral Insufficiency, and Subacute Bacterial Endocarditis.

She was given 20,000 units of Penicillin intramuscularly every four hours for sixteen days, a total of 1,920,000 units from December 21, 1944 to January 6, 1945, during which time her temperature remained normal and she felt much improved.

Two days after the Penicillin was discontinued, she again began to have an afternoon rise in temperature (to approximately 101 degrees) with associated general malaise which continued with no significant improvement to the time of her discharge on January 24, 1945.

During this admission she was treated on the private ward and the discharge note recorded that the patient's family objected to her continued stay in the hospital and to further Penicillin treatment because of the expense involved. She was advised that she should return to the hospital for further treatment if the symptoms persisted.

*Presented at the John F. Kenney Annual Clinic of the Memorial Hospital Internes' Alumni Association, at Pawtucket, R. I., on October 29, 1947.

* Now thirty-five months.

She was readmitted on February 27, 1945, approximately one month later stating that since she had left the hospital she had been confined to bed and had continued to have a low grade fever, general malaise, and recurrence of "plugs" in her fingers and toes.

The examiner noted "that she had lost some ground, and that her heart murmur had increased in intensity, and that she also showed "splinter hemorrhages" (emboli) in her fingers and toes and some sub-conjunctival petechiae". Temperature—102 degrees, Pulse—140, Respirations—24. Laboratory findings were—

R.B.C.—3,900,000
Hgb.—9.5 gms.
W.B.C.—10,250
Differential—83% Polys. 17% Lymphs.
Urine—negative
Blood cultures taken on the day of admission were reported positive for streptococcus viridans.

She was given 20,000 units of Penicillin intramuscularly every four hours for eight days, a total of 960,000 units from February 27, to March 7, 1945, during which time her temperature became normal, her blood cultures became negative, and she was symptomatically improved. The day after the Penicillin was discontinued, she had a recurrence of temperature which continued to spike to 102 degrees and the blood culture again became positive. Two other courses of treatment with Penicillin 20,000 units every two hours from March 22, to March 31, 1945 and from April 26, to May 11, 1945 gave similar results with clinical improvement and negative blood cultures during treatment and a return of symptoms with positive blood cultures on discontinuance of Penicillin therapy.

During this admission of approximately three months, she had three courses of Penicillin of eight, nine and fifteen days respectively, following which she showed clinical improvement with negative blood cultures and on each occasion a return of symptoms with positive blood cultures when the Penicillin was discontinued. In all she received 6,720,000 Units of Penicillin.

She was discharged on May 24, 1945, 13 days after her last course of Penicillin treatment during which time she appeared clinically improved and her temperature remained normal. However, a blood culture taken on the day of discharge was subsequently reported positive for streptococcus viridans.

She was readmitted four weeks later, on June 13, 1945, with the story that she had been in bed since her last discharge. Her fever and malaise had returned, she had become progressively weaker, and she had again begun to have "plugs" (emboli) in her fingers and toes.

Physical examination showed that she had lost considerable ground. She was poorly nourished and appeared chronically and desperately ill. There was an increase in her pallor. Her cardiac murmur had become much louder. Her spleen was palpably enlarged and she showed embolic phenomena in her fingers, toes, and subconjunctivae. Temperature—102 degrees, Pulse—140, Respirations—22, Blood pressure—100/70.

Laboratory findings were—
R.B.C.—3,100,000
Hgb.—9.4 gms.
W.B.C.—13,000
Differential—76% Polys. 24% Lymphs.
Blood cultures taken on the day of admission were again positive for streptococcus viridans.

A review of her previous admissions suggested that Penicillin was beneficial in suppressing the organism and it was felt that larger doses for a longer period of time should be tried in an attempt to obtain a clinical cure.

She was started on 250,000 units of Penicillin every sixteen hours by slow intravenous drip in 1000 c.c. of normal saline alternately with 5% glucose; and 50,000 units of Penicillin intramuscularly every two hours when the intravenous was not running. (total 6,555,000 units)

Sensitivity tests showed the organism to be inhibited by .03125 oxford units per c.c. Blood titration during intravenous administration showed a constant level of 0.25 oxford units of Penicillin per c.c. and during intramuscular administration, a level of 1. unit per c.c. at the end of thirty minutes, .25 unit per c.c. at the end of sixty minutes, .125 unit per c.c. at the end of ninety minutes, and .0625 unit per c.c., or approximately twice the inhibiting level of the organism, at the end of two hours.

The Penicillin was given intravenously for seventeen days, at the end of which time she absolutely refused to have any further intravenous treatment. Therapy was continued for ten more days with 50,000 units of Penicillin intramuscularly every two hours. (6,000,000) The total amount of Penicillin given in twenty-seven days was 12,555,000 units.

On the third day she developed a sudden sharp pain in the left upper quadrant of the abdomen associated with mild shock, muscle spasm, and tenderness over the spleen which was interpreted as a splenic infarction. Except for this incident, she began to show progressive clinical improvement, and her temperature remained normal for the rest of her hospital stay. Weekly blood cultures were negative and she was discharged as improved on July 13, 1945, four weeks after admission.

It is now twenty-eight months* since her last hospital admission. She returned to work two

continued on next page

months after her discharge and has worked regularly since that time. Except for three minor upper respiratory infections, during which she was given prophylactically 600,000 units of Penicillin in oil and beeswax in twenty-four hours, she has remained perfectly well.

All blood cultures taken at approximately monthly intervals since her discharge have remained consistently negative and we feel that we have achieved a clinical cure.

Although this report represents only a single case, the conclusions drawn from our experiences are parallel to those drawn by others who have had an opportunity to observe relatively larger series of cases, namely that the outlook in Subacute Bacterial Endocarditis due to Penicillin sensitive strains of streptococcus viridans is now quite hopeful and a clinical cure can be expected in a large percentage of cases if adequate blood concentrations of Penicillin are maintained for sufficiently long periods of time.

	1	2	3
Admissions	12/13/44—1/24/45	2/27 — 5/24/45	6/13 — 7/13/45
Basic lesion	Rheumatic mitral insufficiency	Rheumatic mitral insufficiency	Rheumatic mitral insufficiency
Blood cultures	Strep viridans	Strep. viridans	Strep. viridans
Embolic phenomena	Finger tips	Finger tips Toes Subconjunctivae	Spleen Finger tips Toes Subconjunctivae
Treatment Penicillin — oxford units	20,000 i/m q4h 16d (1,920,000)	20,000 i/m q4h 8d (960,000) 20,000 i/m q2h 9d (2,160,000) 20,000 i/m q2h 15d (3,600,000)	250,000 i/v q16h 50,000 i/m q2h when i/v not running (6,555,000)—17d 50,000 i/m q2h 10d (6,000,000)
Total	1,920,000 units	6,720,000 units	12,555,000 units
Sensitivity of organism — Inhibited by oxford units/c.c.			0.03125 U/c.c.
Blood titration Penicillin level Cont Intravenous			0.25 U/c.c.
Intramuscular			1. —30 min. 0.25 —60 min. 0.125 —90 min. 0.0625 —2 hrs.
Sequellae	Relapse	Relapse	Recovered 28 mos. plus

DISCUSSION

Raymond W. Young, Ph.D., *Bacteriologist, Rhode Island Hospital*

An interesting observation in the reported case is the fact that the etiologic organism, Streptococcus viridans, did not develop resistance to penicillin. At the time, penicillin was not as available nor as cheap as it is now, and consequently it would seem that an adequate amount of the antibiotic was not given initially nor maintained; this apparently accounts for the three relapses. It is well-known that such a condition favors the development of resistance on the part of

the organism toward the antibiotic, and Streptococcus viridans is particularly prone to adapt itself to the adverse effect of the antibiotic. I have in mind two other cases of the same etiology which followed a similar course with relapses after apparent recovery; however, with each relapse a much increased dosage of penicillin was required to effect any beneficial response. The sensitivity titre of the organisms in each case showed increasing resistance until a point was reached where penicillin gave no response and both patients eventually died. Therefore in the case presented it is remarkable that the sensitivity titre of the organism, which was very low at 0.03U/c.c., remained unaltered after the three relapses and showed no therapeutic indication of increased resistance, even though conditions were ideal for that to occur.

The clinical reports in the literature point out the importance of knowing the sensitivity of an organism in order to know whether or not penicillin therapy will be of any avail. The organisms which are involved in subacute bacterial endocarditis do not have a uniform penicillin sensitivity titre. The more common viridans type, Streptococcus mitis, the common throat alpha strep, occurring in about 50% of the cases of subacute endocarditis, usually has a low sensitivity titre between 0.05 and 0.55U/c.c., but occasionally up to 5 or 10 or more units/c.c. Recently a distinct species of alpha streptococci has been described, having biochemical and cultural characteristics uncommon to any of the other streptococci and occurring only in subacute bacterial endocarditis, so that it is called tentatively Streptococcus s.b.e. The organism occurs in a large percentage of cases reported, from 30-40%. It resists therapy to a greater degree than the common mitis viridans type and represents one of the few instances where there is poor cor-relation between in vitro sensitivity and in vivo therapeutic response. Cases have been reported where this organism showed low sensitivity titre but poor therapeutic response unless dosage of penicillin was greatly increased and maintained. No explanation is offered for the discrepancy, but it may be related to the nature of the lesion produced by this particular species. The lesion may provide a better mechanical barrier effect preventing adequate contact between organism and antibiotic. In several cases reported in the literature where Streptococcus s.b.e. showed even a mild degree of resistance initially, in terms of sensitivity titre, large amounts of penicillin had no influence on the course of the infection. The enterococcus group of alpha streptococci occurring in subacute bacterial endocarditis are often very resistant with a sensitivity titre as high as 250-500U/c.c., in which case penicillin therapy of course, would be of no avail. The remaining miscellaneous alpha streptococci occurring in this infection, such as Streptococcus bovis and Streptococcus agalactiae and other less commonly occurring species usually fall within the range of sensitivity required for effective therapy, that is between 0.05U up to 5U/c.c.

I will comment briefly on dosage and maintenance as related to the sensitivity of the organism. A positive blood culture should be obtained repeatedly, at least twice in order to rule out the possibility of contamination, the organism tested for sensitivity and a blood level of around 4-5 times the sensitivity titre, or the amount required to inhibit the organism, maintained for at least 4 weeks, but longer as indicated. Effective response should render the blood sterile within three days. If this does not occur, the dosage should be increased accordingly. Studies have indicated that a blood penicillin level of 1U/c.c. can be maintained for each million units given daily. The sensitivity titre of most alpha streptococci occurring in subacute bacterial endocarditis usually falls between 0.05 and 0.55U/c.c., but occasionally up to 5U/c.c. With that sensitivity range, 0.5 million units/day for 4 weeks at least is indicated. With Streptococcus s.b.e. or other more resistant species or strains, 2 to 3 million units/day for at least 4 weeks is indicated. If the blood culture is not sterile within 3 days, the dosage should increase to at least 2 million units/day. Clinical reports showing effective response, apparent recovery, indicate an average total dosage of around 50 million units given over a period of 4-5 weeks.

The matter of discrepancy between vitro sensitivity and therapeutic response or in vivo sensitivity seems to concern a number of clinicians. Generally speaking, there is excellent correlation between in vitro and in vivo sensitivity. In other words, if an organism is shown to have a low sensitivity titre it should respond to adequate therapy which will allow at least the inhibiting concentration in the tissues. Where there is poor correlation, a few possible explanations may be offered:

1. The lesions may be too advanced, too extensive for any hope of favorable effect.
2. The lesion may be protecting the organism from the circulating antibiotic, walled off and providing a mechanical barrier effect, so that there is inadequate contact between organism and antibiotic.
3. The organism may be developing resistance because of inadequate dosage, and more rarely in spite of adequate dosage.
4. In a few instances it has been shown that where there is a great difference between the bacteriostatic sensitivity titre and the bactericidal sensitivity titre of an organism, there may be poor therapeutic response even though the organism shows a low inhibiting sensitivity titre.

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CRAWFORD ALLEN HOSPITAL

FOR THE PAST few years the state of Rhode Island Rheumatic Fever program has enjoyed the facilities of the Crawford Allen Hospital as a convalescent home. During the past winter the experiment of moving the convalescent patients to the Rhode Island Hospital has been tried. This was done because of convenience to attending physicians and to secure a close association with the Rhode Island Hospital as a medical center.

At the present moment there are grave doubts as to the feasibility of opening the Crawford Allen Hospital as a convalescent home for the coming summer. The hospital depends for its revenue upon state of Rhode Island rheumatic fever funds and payments by individuals for hospital care. Owing to the present diminution of the number of cases requiring hospitalization the income necessary to open Crawford Allen seems not available.

The rheumatic fever program conducted by the state and the Children's Heart Association of Rhode Island should not be given up. Children suffering from this affliction must not be neglected. It is indeed gratifying to note the decreasing incidence of this scourge of childhood but there still are children who need hospital care for rheumatic fever and there is no means by which we can foretell whether or not there will be an increase in the number of cases in the next year or two. This disease is endemic like other contagious diseases and we must be prepared for future outbreaks. The program as instituted has been most satisfactory and many rheumatic children have benefited.

A hospital must have a definite number of patients to pay the overhead charges. Can we find other means in the interim between outbreaks of rheumatic fever to breach the period of diminishing hospital revenue? Between forty and forty-five patients are needed to insure the opening of Crawford Allen Hospital. The hospital has accommodations for fifty patients.

Certainly there is no reason why other than rheumatics could not be sent to the hospital to help pay the necessary expenses of conducting this most essential hospital unit. Children with other conditions of a debilitating nature would profit by a stay at this delightful spot on Narragansett Bay. Crawford Allen Hospital under the leadership of Dr. Murray S. Danforth was designed for the care of orthopedic cases but with the disappearance of tuberculous bone disease this need no longer exists, but there must be other types of orthopedic conditions which would be benefited by a stay at Craw-

ford Allen. These children could be housed in other than the rheumatic fever wards should there be any feeling concerning the contact with rheumatic fever cases.

Crawford Allen Hospital offers excellent recreational opportunities including a bathing beach far removed from contamination of water in the upper bay. There are playground facilities. Here may be studied the environment from which the child comes and to which it must return and an interpretation made of the child's needs and capacity. Here are opportunities for occupational therapy and the freedom of life in such a place is of benefit to a child.

If physicians throughout the state would keep this matter in mind and realize the importance of not giving up the rheumatic fever program we might be able to find a goodly number of children non-rheumatic who would profit by a stay in the country in which Crawford Allen Hospital is located.

PSYCHOSOMATIC SHIFT

Our outgoing and incoming Presidents of the Rhode Island Medical Society by the nature of their daily work span the entire extent of modern medicine's art and science.

Dr. Ruggles with his head in the clouds of psychic phenomena (or at least on a level with them so that he realizes vividly their stormy disturbances) relinquishes his office to Dr. O'Connell, at home deep in the body handling routinely its most material manifestations as gall stones or bowel cancer.

Possibly Dr. Ruggles would claim the broader experience. There was a time when he demonstrated his ability to diagnose appendicitis and remove the offending vestigial organ. We doubt if Dr. O'Connell would ever dogmatize over schizophrenia or the proper handling of a maniacal patient.

In the past the gamut has been run from skin to bones but never more abrupt change has occurred.

It expresses figuratively the modern conception that our thoughts and our bodily functions are closely interrelated. But, whatever his daily professional work, the state president today has many a perplexing problem of a different nature when he takes office.

The time was when our presidents had to preside in a dignified manner at a meeting or two but had few other disturbing duties. We feel sure that Dr. Ruggles will testify that there is plenty of work and worry associated with the office. He has done a fine job with enthusiasm and fidelity and we congratulate the Society that his successor has shown his ability and willingness to take over a far from easy situation.

"PEDIATRICS"

The new journal, "Pediatrics," the official publication of the American Academy of Pediatrics, has issued its first number in March. As the official journal of the Academy, with the loyalty of the large membership of this society, "Pediatrics" is sure to be one of our best periodicals. In addition to publishing the cream of the clinical papers, it will voice the opinion of the Academy on medical economics and changes in medical care. Libraries and hospitals should have it, and we recommend it to physicians interested in the diseases of children.

THE CHAPIN MEDAL

When the annual meeting of the Society was planned for 1942 the late Dr. Charles F. Gormly, then President of the Society, proposed that an annual lecture be instituted to be known as the Charles V. Chapin Oration. The suggestion was adopted. Dr. Timothy Leary, Professor of Pathology at Tufts College, was designated as the first orator, and his presentation in June, 1942, has been the forerunner of a series of lectures that has already, in the span of six years, attained national recognition.

Another Tufts Medical School leader won the nomination as the orator of the day for the 1943 meeting. Dr. Edwin H. Place, professor of clinical pediatrics, presented a thought-provoking and scholarly treatise on the "Changing Views of Contagious Diseases." Then followed in succeeding years the outstanding papers by Drs. Reginald Fitz, Francis G. Blake, Joseph Stokes, and Stanhope Bayne-Jones.

Taking recognition of the Society's tribute to Dr. Chapin, the Providence City council voted in 1943 that there should be a medal award from the City to the Chapin orator each year. Subsequently an attractive gold and silver medal was designed and struck by the Gorham Company, and awarded by the Mayor of the city of Providence to the Society's Chapin orator.

It was not until this year, however, that the Society and the City cooperated in making possible the award of medals to the first two orators, Drs. Leary and Place. Mayor Roberts graciously took time from his many duties to make the presentations at our mid-winter meeting. The brightness of the occasion was dimmed only by the fact that a convalescence from illness prevented the attendance of Dr. Leary.

It is gratifying to know that the pioneer Chapin orators have received equal recognition with those who followed them.



JOSEPH C. O'CONNELL, M.D.

of Providence, R. I.

President of the Rhode Island Medical Society

1948-49

To the Officers and Fellows of the Rhode Island Medical Society

Again the Rhode Island Medical Society is facing a new year which I believe will present many challenges to our foresight and our ingenuity.

Under the able administration of my predecessor much has been accomplished. Many problems remain for solution in the coming months.

While we must continue to increase our knowledge of and improve our technique in the treatment of individual patients we must also strive to work out in our Society the various public health and National Defense problems which confront us. We must, by study of these problems, be prepared to initiate any desired or salutory laws concerning Public Health rather than to have laws forced upon us by those whose training does not qualify them to dictate our actions. We must in our dealings with the Public so treat them that they will look to us rather than to other sources for help in their medical problems. To prevent unsatisfactory health legislation which will be harmful to the profession and much more so to the Public, we must continue to educate the Public by lectures, radio and individual talks, to offset some of the propaganda which is being used to the detriment of the profession. We must strive unceasingly to improve conditions which we know are not perfect, in order to save the people from the conditions which would prevail under a system of compulsory federal medicine.

We have made great progress in our Voluntary Surgical Plan but there are still some kinks to be ironed out. The Committee in charge of this important matter has worked long and faithfully and deserves our praise and approbation. This plan when started may not be perfect but as flaws are recognized they can be remedied. We have already started a National Defense program which will require a great amount of work on the part of many of our members.

During the coming year the new Veterans Hospital will probably be ready for operation and the Society hopes that it may be of assistance to the Veterans Administration in providing a qualified staff of clinicians and teachers.

We hope that the clouds of war which now seem to be forming will be dispersed but if men must be made ready to preserve our National life, we will strive to the end that the Medical profession will be properly organized to help them do their job, and also to protect the civilian population against any possible war disaster.

Joseph C. O'Connell, M.D., *President*

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THE RHODE ISLAND PLAN

Questions and Answers Concerning the Program for Voluntary Prepaid Non-Occupational Surgical and Obstetrical Insurance Sponsored by the Rhode Island Medical Society in Cooperation with Insurance Companies.

1. *What is the Rhode Island Surgical Plan?*

Briefly, it is a plan developed by the Rhode Island Medical Society to increase the extent to which voluntary insurance against the cost of surgical obstetrical care is made available to the people of Rhode Island, at the lowest practicable cost under competitive conditions. It is especially designed to assist the low-income group to meet the cost of medical care.

2. *Who sells the Insurance?*

Any insurance company licensed in Rhode Island, and Blue Cross, may sell insurance policies under the plan provided such policies are first approved by the State Insurance Department and then by the Rhode Island Medical Society on the basis of principles stipulated by it and aimed to protect and aid those insured.

3. *How will the plan be sold?*

Generally to groups of employed persons where payment of the premium can be made as one payment for those covered. Individual insurance companies will sell policies according to their own sales plans, but policies will be available with some companies to groups of 5 or more. Eventually it is hoped that the benefits of the plan will be available to individuals.

4. *Can dependents be covered?*

Yes. The insured can provide insurance for a spouse and unmarried children between the ages of three months (some policies cover from an earlier age) and 18 or 19 years of age for additional premium. Dependents receive the same indemnities.

5. *Will surgical bills be paid in full under the plan?*

If an individual's total income is below $2,000 a year and his aggregate family income is below $3,000 (and his unearned income does not exceed $500 a year), or if he has dependents and his and their aggregate gross income is below $3,000 a year (and their total unearned income does not exceed $1,000 per year), the benefits of the policy as regards *surgery, obstetrics, assistant's fee* and *anesthesia* will be accepted by participating physicians as full payment for their services.

6. *What about persons not in these income limits?*

Persons above these income limits will have the indemnity fees applied towards the physician's total bill, with such persons liable for any fee charged in addition to the insurance benefit.

7. *Can the insured have private room accommodations at a hospital and still remain in the eligible income group?*

Yes, when such accommodations are deemed necessary by the attending physician. The Rhode Island plan has for its primary purpose complete service to persons in the eligible income group where the services are rendered up to and including a semi-private level, including such extra services as are deemed necessary by the surgeon. If the insured, however, at his own option selects private accommodations he thereby removes himself from the eligible income group.

8. *Does the plan conflict in any way with the Blue Cross?*

No. The benefits paid under it are not covered by the Blue Cross hospital plan. Blue Cross does not provide any indemnity for services by physicians. The insured does not have to be hospitalized to secure benefits under the surgical plan.

9. *What services are included under the plan?*

Surgery in the hospital, the physician's office, or the patient's home, obstetrics, treatment of fractures, anesthesia when given by a licensed physician, and the services of an assistant surgeon when necessary.

10. *What preoperative and postoperative care is provided?*

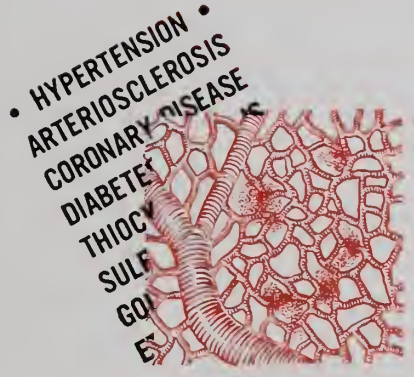
All usual pre- and postoperative *hospital* care.

11. *Are obstetrical benefits immediately available?*

Most policies provide immediate coverage for obstetrical benefits provided the insured employee enrolls under the plan with the group within a specified enrollment period; otherwise a waiting period of nine months is generally imposed. While a nine months' waiting period is generally proposed for dependents, immediate obstetrical coverage may be obtained for them usually with an additional premium required. Persons should inquire about this coverage when purchasing policies.

continued on page 314

to reduce risk of vascular accident



due to

INCREASED CAPILLARY FRAGILITY—

RUPHYLLIN

In diseases in which abnormal capillary fragility is a potential danger (hypertension, arteriosclerosis, coronary disease, diabetes mellitus) or when such increased fragility is connected with use of certain drugs (thiocyanate, sulfadiazine, gold salts, etc.)—Ruphyllin—an important new Searle preparation—offers a means of protection against vascular accident and may be administered over prolonged periods of time.

RUPHYLLIN CONTAINS:

AMINOPHYLLIN (SEARLE) 100 mg.—provides myocardial stimulation, smooth muscle spasmolysis, diuresis;

RUTIN 20 mg.—provides prophylaxis against increased capillary fragility; restores normal tension in capillaries which have developed increased fragility; synergizes diuretic action of Aminophyllin;

PHENOBARBITAL 15 mg.—provides mild and continuing sedation desirable in treatment of hypertensive and cardiac cases.

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RESEARCH IN THE SERVICE OF MEDICINE

RUPHYLLIN IS THE TRADEMARK OF G. D. SEARLE & CO., CHICAGO 80, ILLINOIS.

12. *What obstetrical benefits are included?*

Benefits are provided for delivery, miscarriage, Caesarian sections, and ectopic pregnancies.

13. *Are injuries compensable under the Workmen's Compensation Law covered?*

The plan is designed to cover all injuries *not* compensable under the Workmen's Compensation Law.

14. *What are the limits to the benefits?*

The total for all operations due to the *same or related* cause which are performed during a continuous period of disability is $150 and operations that are not separated by three months shall be deemed to have been performed during such a continuous period of disability, unless clearly unrelated.

15. *Suppose more than one operation is performed at the same time. Are the indemnity payments totalled for determining the benefit, or is the largest indemnity amount paid?*

When more than one operation is performed at one time or in immediate succession, payment will be made for each in accordance with the stated schedule of indemnities. The indemnities are totalled, but in no event is the total to exceed $150. Procedures performed through the same incision shall be considered one operation.

16. *Will the entire schedule of indemnities be incorporated in the policy?*

Most insurance companies will publish the complete master schedule. Some may use an abbreviated schedule, but in every case all policies must provide indemnities according to the master schedule drafted by the Rhode Island Medical Society.

17. *Is the schedule of indemnities permanent?*

The Rhode Island Medical Society has a Health Insurance Committee that will study and report on changes in the plan as experience warrants, in order to provide the best possible protection for the majority of the people.

18. *What indemnity is provided for procedures not listed in the master schedule of indemnities?*

Payment for unlisted procedures will be determined in amounts consistent with those listed in the Master Schedule.

19. *Does the insured person receive the benefit?*

If he is in the eligible income group and selects a participating physician he directs that the indemnity be paid directly to the physician in return for the promise of the physician that the indemnity will cover the cost as listed. If he is not in the eligible income group he may assign the amount of the indemnity to the physician as part payment of the total bill, or he may receive the indemnity himself.

20. *Does the insured person have free choice of physician?*

Any insurance company whose policies are sold under the Rhode Island plan shall not interfere with the insured's free choice of a physician. Only participating physicians, however, are obligated to accept the indemnity as complete payment for service rendered those in the eligible income group.

21. *Who is a participating physician?*

Members of the Rhode Island Medical Society who sign an agreement with the Society to render full service to insurance beneficiaries within the income limits stipulated are listed as participating physicians. Approximately 90 per cent of all active physicians in this state have already agreed to participate in the plan.

22. *How do I know who are the participating physicians?*

A list of participating physicians will be available to all insured persons through the company selling the insurance, or through the Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

23. *Will the list of participating physicians indicate specialists?*

No. But the list will be divided according to areas, and the name and address of participating physicians will be listed.

24. *If service is obtained from a non-participating physician does the insured person have the same coverage?*

He receives the same indemnity benefit, but he will not have the assurance, if he is within the eligible income group, that this benefit will pay the fee in full.

25. *Does the insured person have to purchase other insurance to secure the surgical contract?*

No. The Society has stipulated that an insurance company whose policy is approved under the plan shall not make it a condition of selling it that the prospective policy holder shall take any additional or other form of insurance.

26. *What about medical benefits?*

The plan as approved by the Society is restricted to surgery at this time. As experience is gained it is hoped that medical care without surgery may be added. Some insurance companies do sell medical care riders that may be added to the surgical policy.

continued on page 317



What every Doctor knows...

Every doctor knows that regular laboratory tests are necessary to maintain the quality and purity of any product.

At Hood's, we make constant laboratory tests to be sure the milk from each producer is up to our high standards. We also employ a corps of Country Control Experts who visit each farm frequently to help the dairymen maintain the most modern, most efficient methods of production. No farmer is allowed to ship his milk to our dairy plants unless it meets our rigid requirements!

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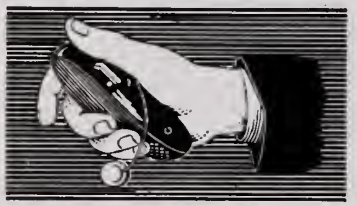
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PROVIDENCE

THE RHODE ISLAND PLAN

continued from page 314

27. *Does the Medical Society determine the premium rates of policies?*

No. The Society is under no obligation whatsoever to review the premium rates of those policies submitted for its approval. The Society desires the premium rates to seek natural levels advantageous to the public through competition.

FRACTURES OF THE SHAFT OF THE TIBIA

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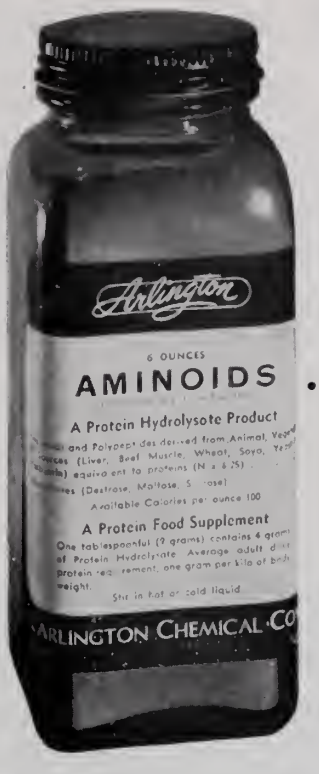
ture of the upper third of the fibula. The admission x-rays sho wslight overriding with lateral displacement of the distal tibial fragment. The leg was manipulated and a cast applied. X-rays taken after this procedure show posterior displacement of the distal tibial fragment with an apparent increase in the overriding. The cast was removed and further manipulation was carried out with the patient on the Bell table. Traction was maintained while the cast was applied. The next x-rays taken February 20, 1947 now show satisfactory position. On March 10, 1947 x-rays were taken which show the fragments to have slipped. The cast was removed and a Kirschner wire was placed through the os calcis. Traction was applied with the leg in a Thomas splint. X-rays taken March 16, 1947 now show the fragments to be in good position again. The traction was maintained until April 25, 1947 when the wire was removed and a plaster cast was applied. He remained in plaster until August 8, 1947. At that time he had clinical union although the fracture line is still visible. At the present time he walks about with no discomfort and has solid union clinically.

N. E. INDUSTRIAL CONFERENCE

The Spring meeting of the New England Conference of Industrial Physicians and Surgeons will be held on Thursday, May 27, at the Bond Hotel in Hartford. An attractive program starting at 11 o'clock in the morning will be climaxed in the evening with a dinner at which a feature address will be given on "How Industry Looks To and At Its Health and Safety Services." Dr. Stanley Sprague, chairman of the industrial health committee of the R. I. Medical Society will lead the discussion on papers to be given in the afternoon on the traning of industrial physicians and nurses, and on trends in health services in small industries.

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APPONAUG
Collom, Harold L.
Lupoli, Alphonse W.

BARRINGTON
Platt, Marden G.

BLOCK ISLAND
Perry, Charles F.

BRISTOL
Bernardo, John R.
Bruno, Paul C.
Clark, Samuel D.
Holdsworth, Hubert

CAROLINA
Laskey, Howard G.

CENTRAL FALLS
Clarke, Elliott M.
Doucet, Charles S.
Farrell, Irving A.

CENTREDALE
Allin, Francis E.
Nourie, Joseph P.

CHEPACHET
Potter, Edgar S.

CRANSTON
Angelone, C. Thomas
Bowen, Earl A.
Cardi, Alphonse R.
Cuddy, Arthur B.
Curren, L. Addison
DeNyse, Donald
Dougherty, Edward F.
Fershtman, Max B.
Hodgson, William H.
Hunt, Russell R.
McAteer, Raymond F.
Nevitt, Francis W.
Rakatansky, Nathan S.
Rossi, Mathew W.
Ruhmann, Warren H.
Seltzer, Bernard B.
Seltzer, Edward I.
Southey, Charles L.
Verrone, Anthony C.
White, George F.
Zouraboff, Catherine

EAST GREENWICH
Baute, Joseph A.
Phillips, Charles L.
Ruhmann, Edward F.
Taggart, Fenwick G.
Young, George L.

EAST PROVIDENCE
Brennen, Earle H.
Fox, A. Henry
Hanley, Francis E.
Joyce, Henry S.
Moore, James S.
Nerone, William S.
O'Brien, John H.
Pozzi, Gustave
Russell, Amy E.
Vaughn, Arthur H.
Vieira, Edwin

EDGEWOOD
Davis, George W.
Pahigian, Vahey
Prior, James H.

HARRISVILLE
Ashton, George W.

HOPE VALLEY
Celestino, Pasquale J.
Nathans, Samuel

HOWARD
Fish, Vera J. W.
Goodman, Louis
Quesnel, Ernest

HOXSIE
Temple, Francis E.

LAFAYETTE
Ladd, Joseph H.

LAKEWOOD
Abbate, Rocco

LINCOLN
Senseman, Laurence A.

LONSDALE
Barnes, Albert E.

NEWPORT
Abramson, Louis
Adelson, Samuel,
Brownell, Henry W.
Burns, Louis E.
Callahan, James C.
Ciarla, Philomen P.
Eckert, George A.
Fletcher, Donald B.
Grimes, M. Osmond
Jerech, Henrietta K.
Logler, Frank J.
Ramos, Jose M.
Rice, Richard
Smith, Daniel A.
Sullivan, Michael H.
Tartaglino, Alfred M.
Tollefson, George A.
Young, John A.
Zamil, Edward
Zielinski, Norbert U.

NORTH PROVIDENCE
Ricci, Edward A.
St. Angelo, Joseph A.

NORTH SCITUATE
Burling, Temple

PAWTUCKET
Barry, Ambrose G.
Beaudoin, Louis I.
Boucher, Reginald H.
Bruno, Rocco
Cormier, Evariste A.
Dufresne, Walter J.
Durkin, Patrick A.
Farrell, Charles L.
Ferguson, Duncan H. C., Jr.
Foster, Edward A.
Fox, G. Raymond
Gaudet, Albert J.
Gerber, Isaac
Gordon, John H.
Hanley, Henry J.
Hanna, Louis E.
Healey, James P.
Hecker, Harry
Hennessey, Kieran W.
Henry, Robert T.
Jeremiah, Bert S.
Kalcounos, William N.
Kechijian, Harry M.
Kechijian, Natalie
Laurelli, Edmond C.
Lovering, Edwin F.
Lynch, John P.
Mara, Earl J.
Marks, Morris
Marshall, J. Brewer
McCaughey, Edward H.
McGinn, James F.
Melucci, Alfred F.
Rohr, Mary-Elaine J.
Ronne, George E.
Schiff, Bencel L.
Sheridan, Thomas P.
Sonkin, Nathan
Sprague, Stanley
Sullivan, James F.
Sweet, Charles F.
Tetreault, Adrien G.
Thompson, Edward R.
Trainor, Edward H.
Triedman, Harry
Umstead, Howard W.
Wheaton, James L.
Woodcome, Harold A.
Zolnian, Hrad H.
Zucker, Joseph M.

continued on page 320

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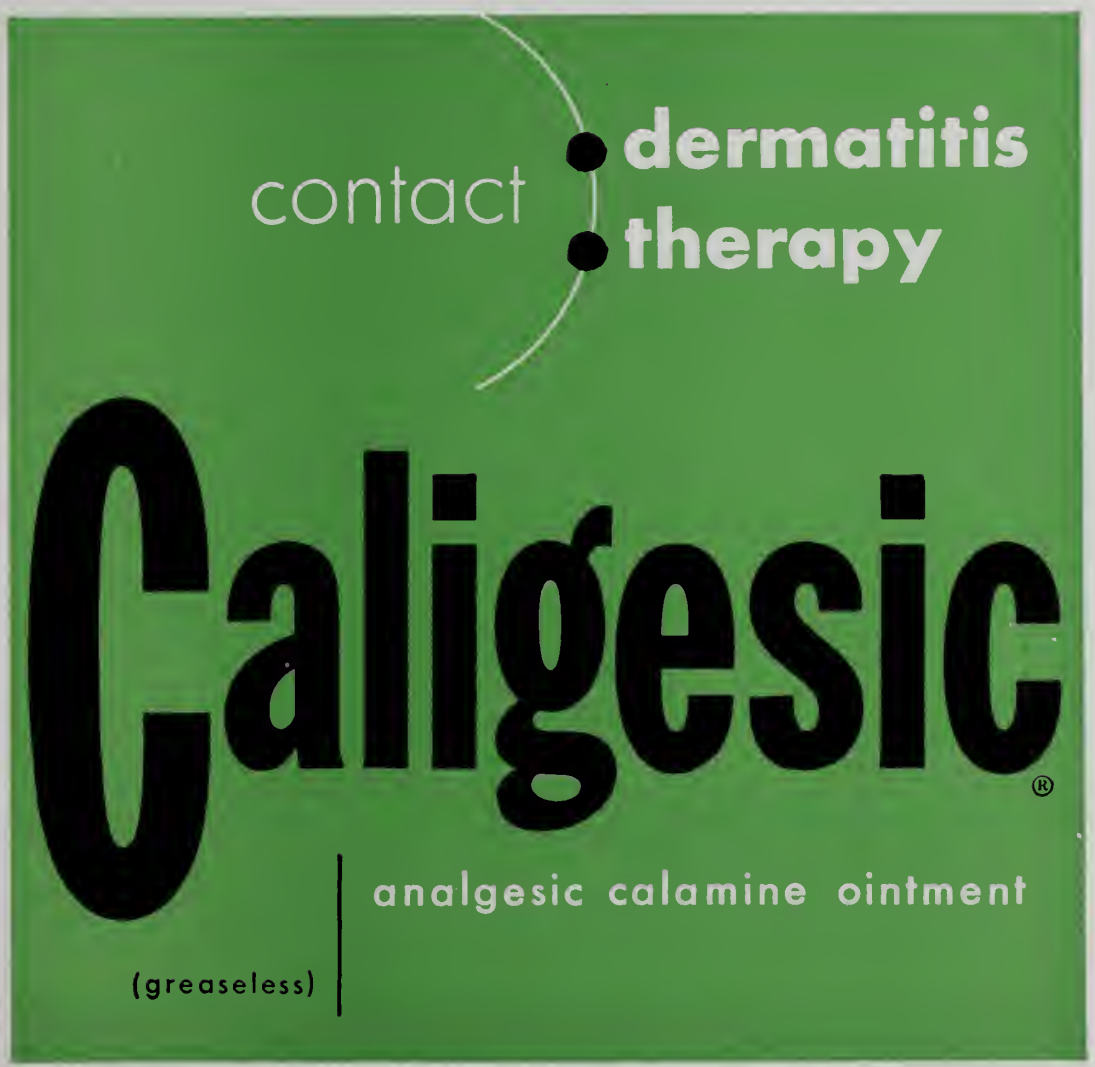
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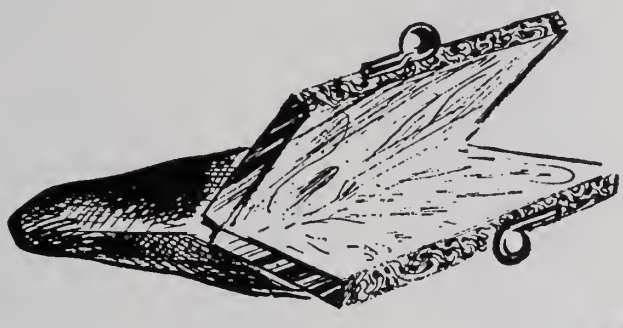
PAWTUXET
Hardy, Arthur E.
Kent, Joseph C.

PEACE DALE
Turco, Salvatore J. P.

PORTSMOUTH
Mallone, John M.
Storrs, Berton W.

PROVIDENCE
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Adelman, Maurice
Alexander, George H.
Archetto, Angelo
Arciero, Michael
Arlen, Richard S.
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Beckett, Francis H.
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Bird, Clarence E.
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Chapian, Mihran A.
Charon, George E.
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Chaset, Nathan
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Conte, Alfred C.
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Cox, James H.
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Cutts, Katherine K.
Cutts, Morgan
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DeWolf, Halsey
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Dotterer, Charles S.
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Egan, Thomas A.
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Fulton, Marshall
Gannon, Charles H.
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Giannini, Pio
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Goldowsky, Seebert J.
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Gordon, Walter C.
Greason, Thomas L.
Greenstein, Jacob
Gregory, Kalei K.
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Luongo, Fedele U.
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Magill, William H.
Mahoney, William A.
Maiello, Robert
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Mamos, Photius D.
Mandell, Israel
Margossian, Arshag D.
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Mathews, Frank H.
Matteo, Frank I.
Mattera, Vincent J.
McCabe, Francis J.
McCoart, Richard F., Jr.
McCusker, Henry F.
McEvoy, Frank E.
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McLaughlin, Edward A.
McOsker, Thomas C.
McWilliams, Joseph G.

continued on page 322



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Gerilac, specifically designed for the aged, is a fortified powder of spray-dried whole milk and skim milk, within the financial reach of all. At a cost of only 19c a day, one reliquefied pint of Gerilac provides 1/3 of the proteins, a full allowance of each of the necessary vitamins* and minerals, and 300 calories in two 8-ounce glasses of tasty drink. And remember, Gerilac is economical because it doesn't have to be mixed with milk.

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Riemer, Robert W.
Riley, Clarence J.
Ripley, Frederic W., Jr.
Rittner, Mark
Roberts, William H.
Robinson, Robert C.
Romano, Anthony
Ronchese, Francesco
Ross, Florence M.
Ruggles, Arthur H.
Ryan, J. Frank
Ryan, Jerome J.
Ryan, Vincent J.
Sage, Louis A.
Saklad, Elihu
Saklad, Sarah
Sammartino, Agostino
Sannella, Lee G.
Sarafian, John C.
Sargent, Francis B.
Savastano, Americo A.
Savran, Jack
Sawyer, Carl S.
Sayer, Edmund A.
Scanlan, Thomas F.
Scorpio, Angelo
Sharp, Benjamin S.
Shattuck, George L.
Sheehan, Linus A.
Sherman, Bernard I.
Silver, Caroll M.
Smith, Bruce W.
Smith, Clara L.
Smith, Frederick A.
Smith, Joseph
Sperber, Perry
Stephens, H. Frederick
Stone, E. Franklin
Streker, John F.
Sweeney, John W.
Sweet, Gustaf
Sydlowski, Edmund J.
Tarro, Michael A.
Thompson, Ernest D.
Tingley, Louisa P.
Troppoli, Daniel V.
Trott, Raymond H.
Utter, Henry E.
Vallone, John J.
Votta, Paul J.
Waterman, George W.
Webber, Joseph B.
Weigner, Walter C.
Wells, Guy W.
Westcott, Niles
Whipple, Richard K.
Whitmarsh, Robert H.
Wilcox, Roswell S.
Williams, Harold W.
Williams, Pearl
Windsberg, Eske
Wing, Elihu S.
Winkler, Herman A.
Wright, David
Yessian, Mark A.
Young, Daniel D.
Zecchino, Vincent
Zinno, Genarino R.
Zurawski, Charles

RIVERSIDE
Bryan, Charles E.
Lagerquist, A. Lloyd
Laufer, Maurice W.

RUMFORD
Webster, Frederick A.

SAYLESVILLE
Chapman, James G.

SCITUATE
Hollingworth, Arthur
Martin, Richard J.

TIVERTON
Lent, James W.

VALLEY FALLS
Kenney, Stephen A.
Sheridan, James J.

WAKEFIELD
Capalbo, Sylvester A.
Gale, Elmer T.
Hathaway, Clifford S.
Jones, John P.
Nestor, Thomas A.
Potter, Henry B.
Thewlis, Malford W.
Tully, William H., Jr.

WALLUM LAKE
O'Brien, William B.
Zambarano, Ubaldo E.

WARREN
Drew, Robert W.
Forget, Ulysse
Giura, Arcadie
Lewis, Luther R.
Merchant, Marcius H.
Millard, Charles E.
Petrucci, Ralph J.

WARWICK
Hackman, Edmund T.

WASHINGTON
Merrill, Whitman

WEST BARRINGTON
Mellone, John A.

WEST WARWICK
Davies, Stanley D.
Duquette, Leo H.
Erinakes, Peter C.
Farrell, George B.
Hemond, Fernand J.
Hudson, Royal C.
Lamb, Francis D.
Mack, John A.
Maynard, Irene G.
Maynard, Jean M.
Scotti, Ciro O.
Senerchia, Giovanni
Tefft, Benjamin F.
Vidal, Jeannette E.
Wittig, Joseph E.

WESTERLY
Agnelli, Freeman B.
Cerrito, Louis C.
Crandall, Harry F.
Farago, Samuel S.
Garrison, Norman S.
Gongaware, Hartford P.
Grenolds, Walter J.
Johnson, Linwood H.
Kenyon, Harold D.
Morrone, Louis A.
Robinson, Mildred I.
Ruisi, Joseph L. C.
Scanlon, Michael H.
Spicer, Albert D.
Tatum, Julianna R.
Thompson, William C.
Warren, Jacob P.

WICKFORD
Menzies, Gordon E.

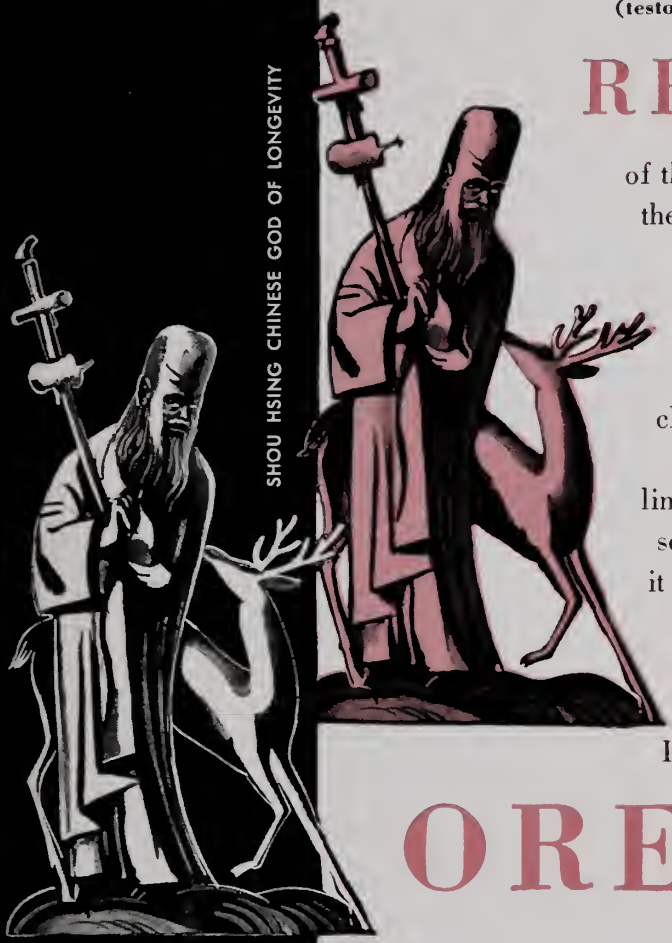
WOODVILLE
Kenyon, Frances A.

WOONSOCKET
Beaudreault, Elphege A.
Boucher, Paul E.
Cohen, Paul
Conlon, Leo V.

continued on page 325

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of the natural testicular hormone in the form of the propionic acid ester of the true primary male sex hormone. ORETON* duplicates the activity of the naturally circulating male hormone in clinical effect. Where once it was believed that this action was limited to reproductive organs and secondary sex characteristics, now it is apparent that ORETON has far-reaching metabolic effects, identical with those of testosterone in the male.

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- ***raising the metabolic rate***[2]
- ***rebuilding muscle substance***[3]
- ***increasing energy and vigor***[3]

Such properties are valuable not only in promoting fullest correction of hypogonadal states but also in checking certain metabolic deteriorations in the aged.

PACKAGING: Ampuls of 1 cc., each cc. containing 5, 10 or 25 mg.; boxes of 3, 6 and 50 ampuls. Also multiple dose vials of 10 cc., each cc. containing 25 or 50 mg.; boxes of 1 vial.

Bibliography: (1) McCullagh, E. P., and McGurl, F. J.: Endocrinology **26**:377, 1940. (2) Thompson, W. O., and Heckel, N. J.: J.A.M.A. **113**:2124, 1939. (3) Goldzieher, M. A.: Geriatrics **1**:226, 1946.

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THE DR. ISAAC GERBER ORATION

On March 10, 1948 the Miriam Hospital staff inaugurated an annual oration to be known as the Dr. Isaac Gerber Oration. We who have known Doctor Gerber these many years might comment at length on his accomplishments, but it is doubtful that we could pay a more eloquent tribute than that of Dr. Merrill C. Sosman, director of the department of radiology at the Peter Bent Brigham Hospital, Boston, which we quote below. To this tribute we add the sincere appreciation of the Rhode Island Medical Society to the staff of Miriam Hospital for its thoughtful action in honoring a Fellow of our Society for whom we all have the greatest admiration

—The Editors

It is a pleasure and a privilege to be with you tonight, and a great honor to be invited to give the first Isaac Gerber lecture. We, in Boston, have known Dr. Gerber for many years and have admired him not only for his ability and his learning, but also for his indomitable courage. He rarely misses any of the important medical meetings in Boston, even during the height of our beautiful winter season, and it is always a stimulus to see him in the audience . His desire to learn, his thirst to acquire knowledge have characterized him ever since I have known him.

Dr. Gerber is essentially a Bostonian, transplanted to the salubrious soil and climate of suburban Providence. He was born in Boston, educated in the Boston English High School, Harvard College and Harvard Medical School, where my researches reveal that he was graduated *cum laude*. He was an intern at the Boston City Hospital and it was there that his future career was determined, but without his realizing it until several years later. At the City Hospital he came into contact with, and fell under the spell of, Francis H. Williams who first interested him in the strange new x-rays, particularly their use in examining the heart and lungs of the patients on his wards. Those of you who knew Dr. Williams will remember what an enthusiast he was, — quiet, scholarly and thorough, but a missionary in thought and deed in those benighted days when physicians thought they could diagnose pulmonary tuberculosis with the stethoscope!

Having been inoculated with the virus of Roentgenology, Dr. Gerber exposed himself to still further infection by studying with Levy-Dorn in Berlin, Haudek and Holzknecht in Vienna, and was a friend and co-worker with Arthur Schüller at the Allgemeine Krankenhaus where his interest in cranial roentgenology was aroused. That was in 1912, the year that Christian and Cushing and their associates toured Europe with the purpose of obtaining ideas and perhaps men for the new Peter Bent Brigham Hospital, about to be opened in Boston the following year. But for a missed appointment with Cushing, Dr. Gerber might have been the new Roentgenologist at my hospital, — and then I would not have been here on this happy occasion.

It is unnecessary to remind you, I am sure, that Dr. Gerber gently metastasized to Providence in 1914, (the first physician in this state to limit his practice to Roentgenology), and of how much he has done for medicine and Roentgenology in the 34 years since he has been one of you. For several years he maintained a base of operation in Boston, but finally recognizing the superior virtues of Providence severed official connection with his native town and has since concentrated his effort in your city. He was active in establishing the department of radiation therapy at the Boston City Hospital in 1924, and a similar one at the Pondville Hospital in 1927. He is or has been on the staffs of most of the hospitals in Rhode Island, belongs to all of our national radiological societies, is a life member of the British Institute of Radiology and is currently, I understand, a Vice-President of the Rhode Island Medical Society. His contributions to the medical literature have been numerous and varied, and I know of no one in our X-ray Societies who has as thorough a knowledge of radiological literature as Dr. Gerber.

Dr. Gerber has always been an Index Medicus and a peripatetic library for our radiological meetings and clinics not only in New England but all over the country.

After accepting the invitation to give this address, I was happy to have Dr. Gerber's suggestion that I speak to you about Pituitary Tumors in general and Pituitary Basophilism, or Cushing's Disease, in particular. Pituitary tumors have in-

terested me continuously for 25 years, and my association with Harvey Cushing gave me an unparalleled opportunity to observe and study them. The historical background is fascinating and the story exemplifies how difficult it is to acquire knowledge in any field of medicine, doubly difficult it seems, when one deals with the endocrine glands and the hormones.

RESPONSE OF DR. ISAAC GERBER

THERE IS very little that one can say in response to such eulogies as have been heaped on me tonight. You all realize of course that this is an extremely unusual occasion, at least from my point of view.

Named lectures generally have been inaugurated in honor of individuals who have already passed on. In the present instance my colleagues and friends of the Miriam Hospital staff have chosen figuratively to send me flowers while I am still around and able to enjoy their fragrance and beauty. It is certainly not for me to decry their choice.

The idea of the annual lectureship in itself is indeed a most admirable one. It is a fitting way of having the hospital, now well along in its third decade of service, show its appreciation of being a real part of the medical community of Rhode Island.

By having a regular stated lecture by eminent, outside medical authorities, the hospital is certainly producing a substantial addition to its usual medical contribution. I sincerely hope that this lectureship will in the future steadily aid in the medical progress of our profession in Rhode Island.

As for myself, I can only state that I am indeed extremely appreciative of the high honor that has been given to me by attaching my name to this projected series of lectures. I am also greatly touched personally by this overwhelming indication of friendliness and esteem on the part of my colleagues in the Miriam Hospital.

I know that you have not gathered here tonight to listen to me. I do not feel that I should encroach further on the speaker's time, and wish once more to express my deepest thanks for this tremendous honor.



DR. ISAAC GERBER

PARTICIPATING PHYSICIANS, The Rhode Island Plan

Crepeau, George A.
Dowling, Richard H.
Eddy, Augustine W.
Emidy, H. Lorenzo
Ferrucci, Dominic
Flynn, Thomas S.
Fontaine, Aurey
Frumson, Solomon L.
Gauthier, Henri E.
Kaskiw, Emil A.
Keegan, George A.
Kennedy, John A.
King, Alfred E.
King, Francis J.
Lalor, Thomas J., Jr.
Levine, Harry
Levy, William S.
McCarthy, James M.
McCooey, James H.
Medoff, Edward B.
Monti, Victor H.
O'Brien, James P.
Reilly, Joseph W.
Rocheleau, Walter C.
Sheridan, Philip H.
Tanguay, J. Edgar
Tremblay, Euclide L.
Tweddell, Henry J.
Vian, George M.
Wittes, Saul A.

OUT OF STATE

Hefferman, Edward V.
(Presently in military service)

Total participating physicians, April 1, 1948—553

DISTRICT MEDICAL SOCIETY MEETINGS

PAWTUCKET MEDICAL ASSOCIATION

The annual banquet of the Pawtucket Medical Association was held March 19, 1948, at the Pawtucket Golf Club. The business meeting was held at noon the same day at the Nurses' Auditorium of the Memorial Hospital.

Application for membership of Dr. Andrew Gerard Czekanski was read and referred to the Standing Committee.

The question of increasing the yearly dues was discussed at length and a motion for this purpose was defeated. It was unanimously voted that a Program Committee of five members be appointed by the Chair for the coming year, starting with September meeting, the topics to be published in advance. If a deficit results, an assessment up to $25 shall be made.

The business meeting adjourned to the banquet which followed at 6:30 p. m. at the Pawtucket Golf Club.

The following slate of officers were unanimously re-elected for the coming year:

President: Earl J. Mara, M.D.

Vice President: John Gordon, M.D.

Treasurer: Laurence Senseman, M.D.

Secretary: Kieran Hennessey, M.D.

Delegates:

Earl Mara, M.D.
Charles Farrell, M.D.
Robert T. Henry, M.D.
Henry J. Hanley, M.D .

Standing Committee:

G. Raymond Fox, M.D.
Joseph H. Doll, M.D.
Armand A. Bertini, M.D.
Edward H. Trainor, M.D.
William N. Kalcounos, M.D.

Dr. Mara thanked the members for their confidence and promised that the meetings would be better and more appealing to all. He asked for increased support.

Dr. G. Raymond Fox presided ably as toastmaster and following the banquet a number of door prizes were distributed. The members were then entertained by a magician and his troupe.

The meeting adjourned at 9:40 p. m. Thirty-nine members attended.

Respectfully submitted,

KIERAN W. HENNESSEY, M.D., *Secretary*

NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport County Medical Society was held at the Newport Hospital on Tuesday evening, March 23, 1948, with seventeen members attending.

The meeting was called to order at 9:00 p. m. by Dr. Philomen P. Ciarla, President.

Dr. Lewis Abramson moved that the application of Frank A. Stewart, M.D., for membership be accepted. This was seconded by Dr. Frank Logler and unanimously approved by the body.

Dr. Henry W. Brownell moved that the Treasurer, Dr. Norbert Zielinski, list the members that had not paid their dues to the Newport County Medical Society and further moved that if after notification these members refused payment that they be dropped from membership. The motion was seconded by Dr. Osmond Grimes and approved.

Dr. Philomen Ciarla recommended that the county society, as a whole, should object to those newspapers that have continued, in spite of previous objections, to publish individual doctors' names.

Guest speakers of the evening were Doctors Henry E. Utter and William P. Buffum of Providence whose spirited talk on "Upper Respiratory Disease in Childhood and its Relation to Allergy" precipitated a lively thirty minutes' question and answer period. The factors in the spread of upper respiratory disease, the types of infections, the preventive measures, the relationship of recurrent respiratory infections to an allergic background and the role of the chemotherapeutic agents were touched upon.

The meeting adjourned at 11:00 p. m. A collation was served.

Respectfully submitted,

JOHN M. MALONE, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Kent County Medical Society was held at the Dreyfus Frog Farm in Warwick, Tuesday, March 9, 1948. After dinner the meeting was called to order at 10:20 p. m. by the President. Reading of the minutes of the last meeting was dispensed with in the absence of the Secretary. Dr. Vidal called upon Dr. Edmund Hackman to act as Secretary pro-tem.

Dr. Francis Temple of Hoxie was voted in by the assembly as a new member.

The speaker of the evening, Dr. Henry E. Utter, then gave an important interesting talk on "Office Pediatrics." After discussion by the members of mutual problems in the practice of pediatrics, Dr. Utter was given a rising vote of thanks.

Motion to adjourn was made and seconded at 11:30 p. m.

EDMUND HACKMAN, M.D.,
Secretary Pro-tem

WOONSOCKET DISTRICT MEDICAL SOCIETY

The first Spring meeting of the Woonsocket District Medical Society was held on April 13, 1948, at 9:00 p. m. at the St. James Hotel. The meeting was called to order by the President, Dr. Richard H. Dowling at 9:20 p. m.

The applications of Drs. Philip H. Sheridan, Alton P. Thomas, Dominic P. Ferrucci, and Charles E. Brochu were considered and accepted. They were unanimously elected members of the Society.

Dr. Francis J. King discussed a committee meeting with the publisher of the *Woonsocket Call* regarding Chiropractic advertisements. It was revealed that the publisher agreed to omit statements regarding definite claims of cure. It was noted by some of the members that the character of the advertisements had not changed much since the discussion.

Dr. Henry E. Gauthier talked about his attendance at meetings of the State Society committee for Prepaid Surgical Insurance. The difficulty concerning the low income bracket inclusion was discussed.

There being no further business to come before the Assembly, the meeting was adjourned at 9:55 p. m.

Respectfully submitted,
ALFRED E. KING, M.D., *Secretary*
Woonsocket District Medical Society

continued on next page



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PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, April 5, 1948. The reading of the minutes of the previous meeting was omitted by consent of the members present.

Dr. Daniel V. Troppoli, Secretary, read a communication from Dr. Reginald Fitz, orator on the occasion of the Association's Centennial, thanking the Association for the resolution adopted at its meeting on March 1, 1948 commending him for his contribution to the Centennial program. Dr. Frederick Webster presented the following resolution relative to the College of Pharmacy.

WHEREAS, the field of therapeutic medicine has been and is being increasingly augmented by the discovery of new and powerful drugs and remedies, and

WHEREAS, the physicians of this City and State depend in great measure upon trained pharmacists for the careful preparation and dispensing of drugs and remedies prescribed by them, and

WHEREAS, every opportunity should be made available within our State for the proper and adequate training of young men and women for a career in pharmacy in the interest of community health.

THEREFORE, BE IT RESOLVED, That the Providence Medical Association express its full endorsement of the building fund campaign of the Rhode Island College of Pharmacy and Allied Sciences, and further that it urge the generous financial support of the citizens of this State for this outstanding educational institution.

The resolution was seconded and unanimously adopted.

The scientific program was started with the showing of a motion picture with sound on Gastroscopy presented by Harrower Laboratories which showed the development of the gastroscope from the early days the Germans got the idea from watching a sword swallower to the modern instrument.

It was demonstrated that aluminum hydroxide and trisilicate when given with muccin formed the best coat over the ulcer and stomach mucosa.

It stressed the importance of using both x-ray and gastroscopy for accurate diagnosis of stomach disease.

Dr. Walter C. Weigner, Assistant Physician, Outpatient Department, Department of Neurology and Psychiatry, Rhode Island Hospital, presented the first scientific paper on the subject "Ascending Paralysis—Complete Recovery".

Dr. Weigner presented an excellent bibliography of Laudry's Ascending Paralysis and then presented a case unique in that the patient survived two attacks of a malady which is usually fatal.

The criteria to be met in making a diagnosis of Laudry's Paraylsis are:

1. Rapid Onset
2. Motor involvement only
3. No sphincter disturbance
4. No pathological changes

At present about 30% of cases show pathological changes and these are in the anterior horn cells.

Dr. Batchelder announced that in continuance of the policy initiated at the March meeting of having a representative of a local health and welfare agency address the members, he had invited Mrs. Edward H. Fuller, Executive Secretary of the Providence League for the Hard of Hearing to speak to the Association. Mrs. Fuller explained the work of the League for the Hard of Hearing stating that three years ago a committee was formed to select hearing aids for the deaf. Prior to this, these patients bought aids which were not the proper ones for their specific needs and could not use them.

The committee saw dealers who loaned them a model of each type. The patients are tested impartially and the proper aid selected and patient referred to the proper dealer to obtain it. There are at least twelve different hearing aids on the market. She appealed to the Doctors to acquaint patients with the work of the Hard of Hearing Society. The longer a patient goes without hearing sound, the more difficult it is for them to get used to it again.

In addition they conduct classes in lip reading for those whose hearing loss is not too great. She made the startling statement that one out of every twenty-five children of school age develop hearing difficulty.

The final scientific paper of the evening was given by Dr. Vincent J. Oddo, Surgeon-in-chief, Urological Department, St. Joseph's Hospital.

Dr. Oddo presented a new technique for radical cure of a hydrocele that he had performed on eighteen patients without recurrence.

He presented slides showing the pathology of the tunica vaginalis in hydrocele.

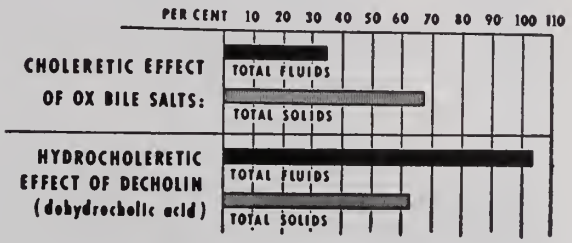
The commonly used operation is the bottle operation. He feels this leaves a large mass of tissue, causes hematoma and adhesions. Some reef the tunica instead of everting it. In another technique the tunica is excised.

The author has a new physiological principle. He feels hydrocele is due to trauma or infection hence the pathological picture of chronic inflammation. In the author's technique, he makes an incision in the tunica vaginalis about three-quarter to one inch long and sutures the edge with eversion. A drain is placed inside the tunica and it is removed in twenty-four hours.

The meeting adjourned at 10:10.

Respectfully submitted,
DANIEL V. TROPPOLI, M.D., *Secretary*

DECHOLIN HYDROCHOLERESIS Encourages Biliary Tract Drainage



● **Percentage Increase in Composition and Quantity of Bile Flow**

Ivy, A. C., et al: Am. J. Dig. Dis. 7:333 (Aug.) 1940.

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by producing an increased flow of bile—washes stagnant, infected bile from the intrahepatic and extrahepatic biliary passages, removing pus-laden material and discouraging the ascent of infection.

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POSTGRADUATE MEDICAL EDUCATION IN RHODE ISLAND

Compiled by the Committee on Postgraduate Education of the Rhode Island Medical Society

THE FOLLOWING is a list of meetings, clinics and similar educational exercises held at the various hospitals which members of the Rhode Island Medical Society are privileged to attend. Through the cooperation of the hospitals listed the medical profession of the state is thus offered an excellent opportunity to keep touch with modern medicine in its various branches.

Although practically all the conferences listed below are held regularly as scheduled it is advisable that physicians planning to attend them communicate with the hospital ahead of time to make certain that the conference will be held.

BUTLER HOSPITAL

(GAspee 3456)

Conferences and Seminars

Special arrangements should be made by individual physicians wishing to attend these exercises by communicating with the Superintendent, Dr. David G. Wright.

* * * *

CHARLES V. CHAPIN HOSPITAL

(DExter 7400)

Monthly staff meeting (C-P-C)

Third Wednesday every month except July and August.

Department of Pediatrics

Tuesday, at 11:30 a. m., lectures by resident and visiting staff members.

Thursday, at 11 a. m., pediatric ward rounds and conference.

Department of Neuro-Psychiatry

Thursday, conference from 10 to 11 a. m.

Daily, observation of insulin coma treatments.

Monday, Wednesday, Friday, 8 a. m., electric shock therapy.

Department of Tuberculosis

Monday, at 11 a. m., conference on pulmonary tuberculosis and related pulmonary diseases.

* * * *

PAWTUCKET MEMORIAL HOSPITAL

(PErry 3021)

Clinicopathological Conference

Clinicopathological Conferences have no set date. Check with hospital.

Demonstrations and Reviews of Pathology

Demonstrations and reviews of pathology by Dr. B. Earl Clarke and Staff on second and fourth Thursdays at 11:15 a. m. in the X-Ray Department.

Medical Service

Grand Ward Rounds at 10:30 a. m. every Monday.

Thoracic Clinic at 10:30 a. m. every Wednesday.

Conference at 10:30 a. m. every Thursday followed by Pathological lecture.

Surgical Service

Grand Ward Rounds at 10:30 a. m. every Tuesday.

Surgical Conference on the second Tuesday of the month at 11 a. m.

Daily Ward Rounds at 10:30 a. m. except Wednesday when they will be held at 9:30 a. m.

Tumor Clinic

The first and third Thursdays of each month at 10:00 a. m.

Urological Service

Ward Rounds at 10:45 a. m. every Tuesday.

Ward Rounds followed by conference on the last Tuesday of the month.

Pediatric Service

Ward Rounds and Conference at 11 a. m. on the first and third Friday of each month.

Orthopedic Service

Ward Rounds at 9 a. m. every Monday.

Health Maintenance Clinics for Cancer Prevention

(By invitation only)

Every Monday at 11 a. m.

Obstetrical Service

Ward Rounds and Conference at 10 a. m. second Friday of the month.

Neurological Service

Ward Rounds at 7:30 p. m. in the X-Ray Department on the second Thursday of the month.

* * * *

continued on page 334

to help vanquish depression marked by "morning tiredness"

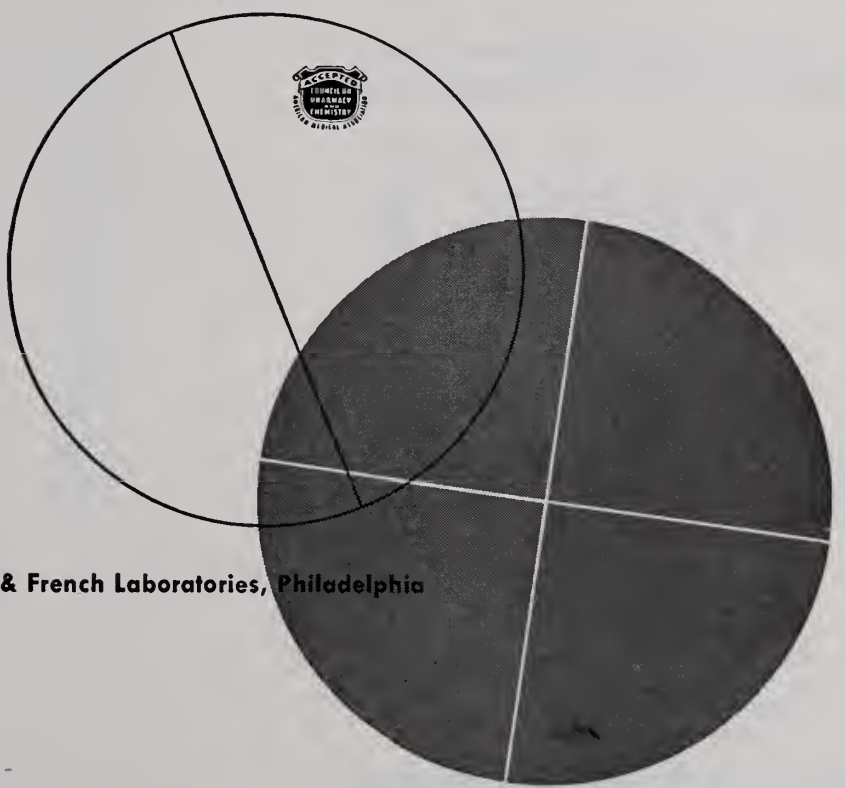
Many depressions are marked by morning tiredness, inertia, lassitude and retardation. 'Benzedrine' Sulfate, taken on awakening, frequently helps to lift the patient "over the hump" of the early hours.

Benzedrine Sulfate—where it shortens, eases, or even eliminates the patient's struggle with depression—may improve the tone of his entire day. While not always effective, Benzedrine Sulfate therapy certainly merits a fair clinical trial in depression marked by morning tiredness.

Tablets Capsules Elixir

Benzedrine* Sulfate

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POSTGRADUATE MEDICAL EDUCATION IN RHODE ISLAND

continued from page 332

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(DExter 3200)

X-Ray Conference
Tuesday at 11 a. m.

Staff Conference
Thursday at 9 a. m.

Members of the medical societies are cordially invited.

* * * *

RHODE ISLAND HOSPITAL

(DExter 4300)

Cancer
Tuesday, 11 a. m., Cancer Detection Clinic—Clinic Building.
Wednesday, 10 a. m., Tumor Clinic—Clinic Building.

Dentistry
Friday, 9 a. m., Follow-Up Clinic—Clinic Building.

Dermatology
Monday, 10:30 a. m., Clinical Demonstration Conference—Out-Patient Department.

Eye
Thursday, 9 a. m., Teaching Eye Rounds—Ward A.
First and third Sundays, 11 a. m., Eye-Nerve Clinic—Potter Building Classroom.

Fracture
Friday, 11 a. m., Grand Rounds—Ward B, H, and Potter Building.

Gynecology
Monday, 1 p. m., Tumor Clinic—Clinic Building.
Tuesday, 9 a. m., Follow-Up Clinic—Clinic Building.
Tuesday, 10:30 a. m., Grand Rounds—Ward I.

Medicine
Tuesday, 10 a. m., Grand Rounds—Wards A and K.
Wednesday, 10 a. m., Grand Rounds—Wards A and K.
Thursday, 9 a. m., Gastro-Intestinal Clinic—Clinic Building.
Thursday, 11:30 a. m., Thoracic Clinic Conference—Clinic Building.
Friday, 11 a. m., Department of Cardiology—Conference—Heart Station.
Saturday, 10:15 a. m., Conference—Peters House.

Neurology and Psychiatry
Saturday, 9:15 a. m., Conference — Peters House.

continued on page 337



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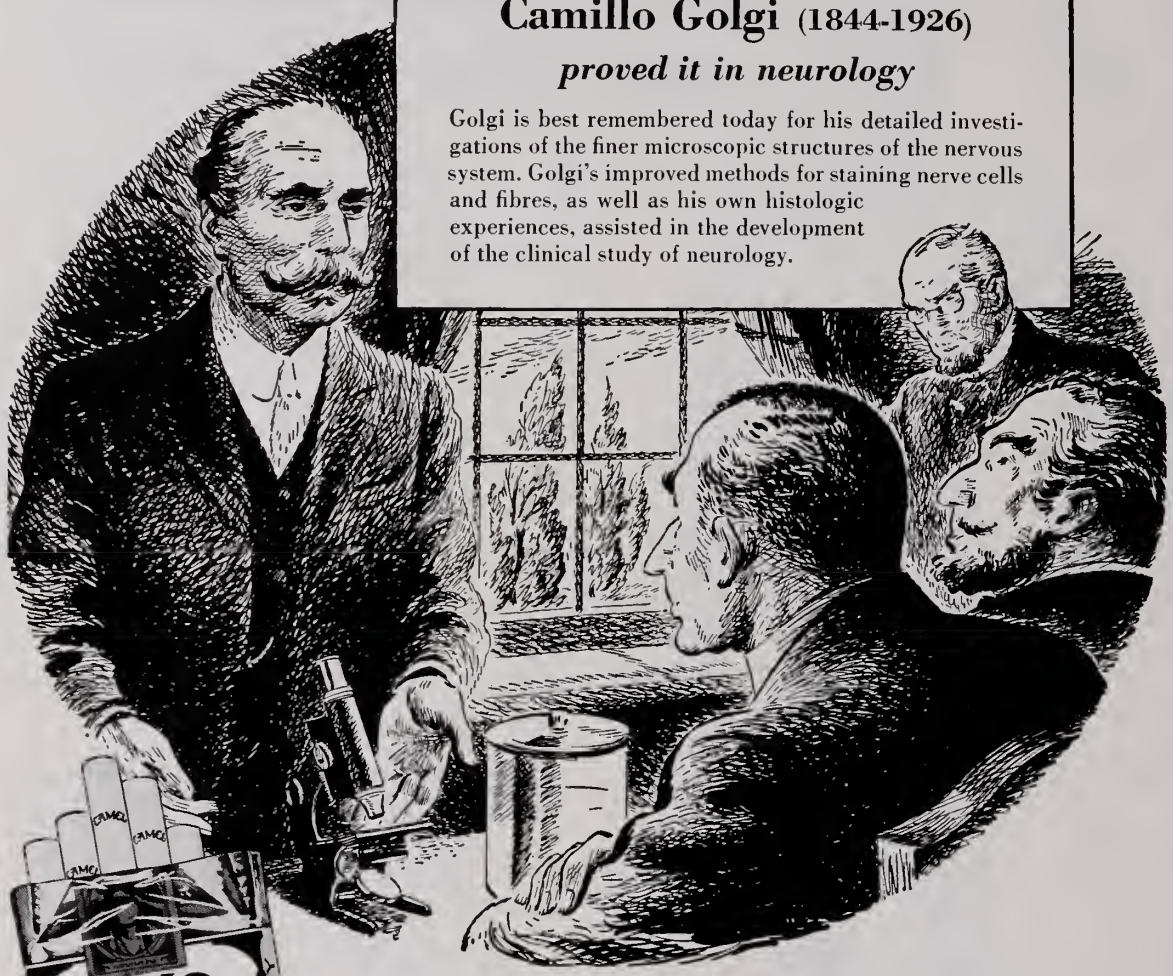
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proved it in neurology

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Yes! Let your own experience tell you why more people are smoking Camels than ever before.

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More Doctors Smoke CAMELS
than any other cigarette

Three leading independent research organizations in a nationwide survey asked 113,597 doctors what cigarette they smoked. The brand named most was Camel!

POSTGRADUATE MEDICAL EDUCATION IN RHODE ISLAND

concluded from page 334

Orthopedics

Thursday, 9 a. m., Grand Rounds—Wards B, H and Potter Building.

Pathology

First and third Tuesday, 12 Noon, Clinico-pathological Conference—Peters House.

Pediatrics

Friday, 11 a. m., Grand Rounds—Potter Building.

Surgery

Monday, 9 a. m., Peripheral Vascular Clinic—Clinic Building.

Monday, 9 a. m., Department of Neuro-Surgery, Grand Rounds—Ward C.

Monday, 10:30 a. m., Grand Rounds—Wards C or D.

Tuesday, 10:30 a. m., Grand Rounds, Ward C or D.

Friday, 12:00 Noon, Staff Conference—Peters House.

Urology

First and Third Thursday, 11:30 a. m., Grand Rounds—Ward C.

* * * *

ROGER WILLIAMS GENERAL HOSPITAL

(GAspee 1625)

Tumor Clinic

First and Third Thursday of each month at 10 a. m.

Pathological Conference

Second Friday of each month at 12 Noon.

These conferences are open to any and all physicians.

* * * *

STATE SANATORIUM AT WALLUM LAKE

(Pascoag 22)

Staff Conferences

Daily from 11 a. m. to 12:30 p. m.

Thoracic Surgery

Every Tuesday, starting at 9:00 a. m.

Staff Meetings

Monthly every second Wednesday night at 8 p. m.

All physicians are invited to come to the Sanatorium at any time and the staff will be glad to acquaint them with what is being done.

* * * *

STATE HOSPITAL FOR MENTAL DISEASES

(HOpkins 4700)

Journal Clubs and Pathological Conferences

Alternate on Mondays at 1:30 p. m.

Staff Conferences

When a single psychiatric case is discussed in some detail, staff conferences are held Tuesdays and Fridays from 1:30 to 2:30 p. m.

It would be desirable for any physician planning to attend, to telephone HOpkins 4700 before driving to the hospital in order to avoid disappointment in the event of a cancellation which occurs occasionally.



...FOOT ACTION!

THE mechanical foot action of Hanger Artificial Legs allows a close approximation of natural walking for their wearers. The forward and backward motion and rubber cushions absorb shock and give the flexibility of motion so important in maintaining an even stride. This is one more example how the goal of Hanger design and development is to allow the amputee to resume life's normal functions. Throughout, Hanger Limbs are constructed of a few parts simply assembled to reduce unnecessary breakdowns and repairs.

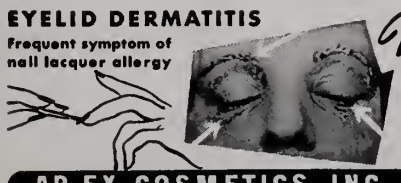
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MEDICAL LIBRARY NOTES

SYMPOSIUM ON MEDICOLEGAL PROBLEMS. Edited by Samuel A. Levinson, M.D., PH.D., University of Chicago College of Medicine. *J. B. Lippincott Company, Publishers.*

This book of 249 pages is a review of meetings of the Institute of Medicine of Chicago and the Chicago Bar Association. The contents bring out, as the foreword states, "Because of the education and training that is given to the members of both professions and the opportunities inherent in their practice, they very clearly have a public duty to perform in the community. Those duties . . . extending into public welfare generally."

Among the problems discussed are Expert Testimony, The Medicolegal Implications of Artificial Insemination, The Medicolegal Problems of Pathology, Medicolegal Implications of Operations to Produce Sterility, Trauma in the Causation of Tumor, Blood Grouping in Paternity Cases, Chemical Tests for Intoxication.

The scientific presentation is made by medical men or men skilled in a scientific field and the legal viewpoint is presented by men learned in jurisprudence.

The presentations are excellently given and the legal viewpoint is excellently stated. The question periods allowed at the end of the presentations bring out diverse viewpoints, all of which are provocative of further thought.

The thing the scientific presentation seems to miss can be adequately expressed by the word of the late Justic Holmes viz. "The life of the law is not logic but expediency." However, when logic can be reconciled with expediency, i.e., when it becomes expedient to be logic, the scientific viewpoint may ultimately be so disclosed.

The clash of the numerous private and social interests is well demonstrated. The natural bias of attorneys representing individual interests as against corporate and state interests is obvious in the questions put to the speakers.

Throughout the book it is ideal that there is full and open discussion — without thought of embarrassment by putting the other fellow "on the spot."

Of course, the whole field of medicolegal matters is not covered. To do so would take volumes. The present monograph, however, is an excellent beginning and might well serve as a model for future symposia conducted by the medicolegal associations of the several states.

J. Francis Daurman has finely prepared a foreword. The publishers have made the format of the book such that it is readable without fatigue. The speakers and their questioners have well discussed the problems presented and have left the reader with plenty of material for consideration.

Whether one appears in court or not, whether one is vitally interested in the subjects presented or not, the book is recommended for its stimulation of thought and also to show the practical difficulties that beset the reconciliation between that which is logic and/or expedient.

WILLIAM H. FOLEY, M.D.

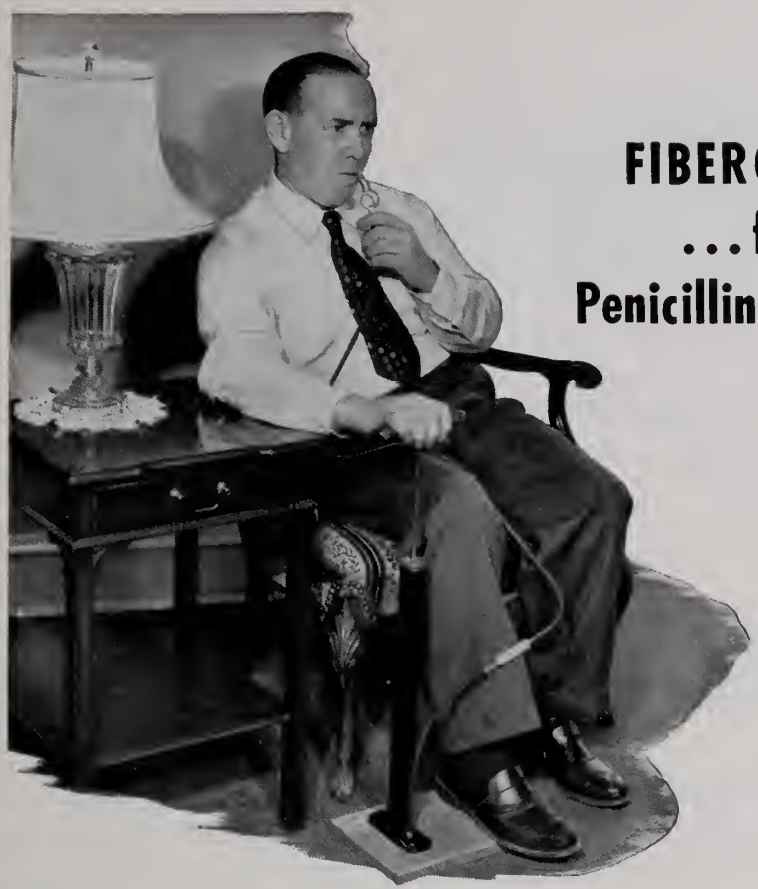
A PRIMER OF CARDIOLOGY, by George E. Burch, M.D. and Paul Reaser, M.D. *Lea & Febiger, Philadelphia, 1947,* $4.50.

This book has been designed for use of students of medicine and for the physician who is beginning the study of cardiology and is remarkable because so much sound information has been condensed into such little space. The book shares with many other clinical textbooks the tendency to explain diseases of the heart and circulation on physiological grounds. In covering the more important aspects of the subject, the authors have made use of diagrams, sound records, phlebograms and pulse tracings in such fashion as to cover a mass of data in a short space.

General anatomic considerations, approach to the diagnosis of heart disease and the approach to a clinical cardiac evaluation (an excellent section), are treated in three general chapters. The remaining 100 pages are taken up with a discussion of the various types of heart disease and the bedside diagnosis and treatment of cardiac irregularities.

The statement on page 196 that the electrocardiogram in interventricular septal defect usually shows right axis deviation is at variance with the reviewer's experience. Although the book contains no material that could not easily be discovered in current texts on clinical cardiology, it will undoubtedly prove popular and can be highly recommended for the beginning student in cardiology.

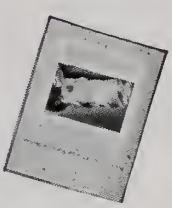
HENRY MILLER, M.D.



FIBERGLAS* FIBERS ...filter air for Penicillin Aerosol Therapy

An inexpensive nebulization pump designed for simplifying penicillin aerosol therapy for home treatment has recently been reported †. A glass vial containing Fiberglas fibers is inserted at the end of the rubber hose of an ordinary bicycle pump and attached to this is a rubber tubing leading to the penicillin nebulizer. The Fiberglas fibers are used to filter the air when the pump is in operation. They help eliminate any foreign matter in the air stream and prevent plugging of the apparatus.

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†Finke, Walter, M.D., Simplification of penicillin aerosol therapy for home treatment, American Practitioner 1: 643-644, Aug. 1947.

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BOOK REVIEWS

MINOR SURGERY, 6th Ed. Frederick Christopher. Philadelphia, *W. B. Saunders Co.*, 1948.

Christopher's *Minor Surgery* needs no introduction to the medical profession. It has been, and is still, an essential part of the general practitioner's and general surgeon's library. The sixth edition maintain the high standards and general form of its predecessors. There are only a limited number of changes necessary, inasmuch as the last edition was published only four years ago, but many new departures in treatment are covered.

Among the sections containing important revisions and additions are the passages devoted to thrombophlebitis, burns, and the local and parenteral use of antibiotics. There is also new material on gelatin sponge and oxidized cellulose, procaine in serum sickness, intra-arterial injection of penicillin, surgery of bedsores, placement of neck incisions, refrigeration anesthesia, and other items of current interest.

One of the most valuable features of the volume is the profuse number of references. While the book is necessarily influenced by the opinion of the author, he is broadminded enough to present various points of view and to document nearly every statement with references to the works of others.

As compared with editions older than the last previous one, the new sixth edition contains much more new material. For those who do not own one of the two most recent editions there is enough fresh material to warrant purchase of the new one.

THOMAS PERRY, JR., M.D.,

UNIPOLAR LEAD ELECTROCARDIOGRAPHY, by Emanuel Goldberger, B.S., M.D. *Lea & Febiger, Philadelphia, 1947*, $4.00.

Unipolar leads represent a natural phase in the development of electrocardiography. For years electrocardiographic interpretation was based on analyses of the three standard leads alone. In more recent years, electrocardiographic leads in which a small exploring electrode placed over the precordium is paired with an electrode placed on the back or upon one of the extremities have come into widespread use. Because standard leads are complex and represent the difference between the electrical potentials at two points of the body, some criticism of the interpretation of such records has been raised. With the introduction of unipolar leads, there has occurred a gradually increasing appreciation of their clinical value. This small book is the result of Goldberger's extensive studies on this subject.

This new system of electrocardiography consists of three "augmented" unipolar extremity leads

continued on page 343



Echoes from assorted chocolates?

One slip in her prenatal diet so easily leads to another—from a tempting giftbox of favorite chocolates, for example, to steak and French fries and from there to further whims of capricious appetite. To make sure the patient will receive a sufficient daily amount of essential minerals and vitamins—if old habits do tempt her to stray from the dietary path—many physicians prescribe a regular mealtime addition of easy-to-take DICALDIMIN Capsules. DICALDIMIN supplies protective amounts of both minerals and vitamins: iron, calcium, phosphorus and vitamin D plus B complex factors. DICALDIMIN provides a sufficient amount of vitamin D in the form of viosterol to meet the entire requirement for this factor during pregnancy and lactation. And the new DICALDIMIN WITH VITAMIN C supplies still another dietary. Both products are available now at your favorite pharmacy in bottles of 100 and 1000.

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Folic acid . . . . . 5 mg.
Calcium pantothenate . . . . . 10 mg.
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BOOK REVIEWS
concluded from page 340

(the aV leads) and the precordial leads each of which represents potentials from only one region of the body. The first part of the book is devoted to a description of the physiologic principles underlying the use of "augmented" unipolar extremity and precordial leads and the technique of obtaining such leads. This is followed by a discussion of the value of these leads in determining the position of the heart in the thoracic cavity. The second section of the book considers various abnormal electrocardiographic patterns. The discussion is well organized; in some instances more electrocardiograms would have been desirable for greater clarity.

Unipolar extremity leads may be of value in the interpretation of abnormalities of the Q waves, especially Q_3, and it is claimed that they may be useful in the differentiation of pulmonary embolism from posterior myocardial infarction, the diagnosis of small myocardial infarcts, the diagnosis of right ventricular hypertrophy, the interpretation of tracings with abnormalities of the RS-T segment and T wave, and the interpretation of tracings with minimal changes in the standard leads. The book deserves wide circulation. It is clearly written and well organized. It is to be hoped that the study and use of these leads, in conjunction with standard leads, will lead to a fuller understanding of various electrocardiographic patterns.

HENRY MILLER, M.D.

YOU AND YOUR DOCTOR, by Benjamin F. Miller, M.D., Clinical Professor of Medicine, George Washington Medical School. *Whittlesey House, publishers, New York*, $2.75, 1948.

This book is a discussion of medical practice and problems in the United States, written primarily for the laity. The author presents all of the disadvantages and none of the advantages of the system of general practice and the reverse of group practice. He would abolish the general practitioner and substitute in his place a "pilot physician" whose chief function would be to route patients to the proper specialist. The inadequacies of modern medical and scientific education and research are vividly and aptly brought to the attention of the reader. A plan for the correction of medicine's dilemma is offered.

The author advocates government subsidization of medical education, research, and patient care based on a system of specialists groups and pilot physicians, financed by a form of compulsory insurance. Administration would be by the United States Public Health Service.

The book is well written and easily read. While it discusses a highly controversial subject it presents several worthwhile ideas and should serve well as an introduction to many of our health problems. Briefly, however, it is a demand for the socialization of medicine.

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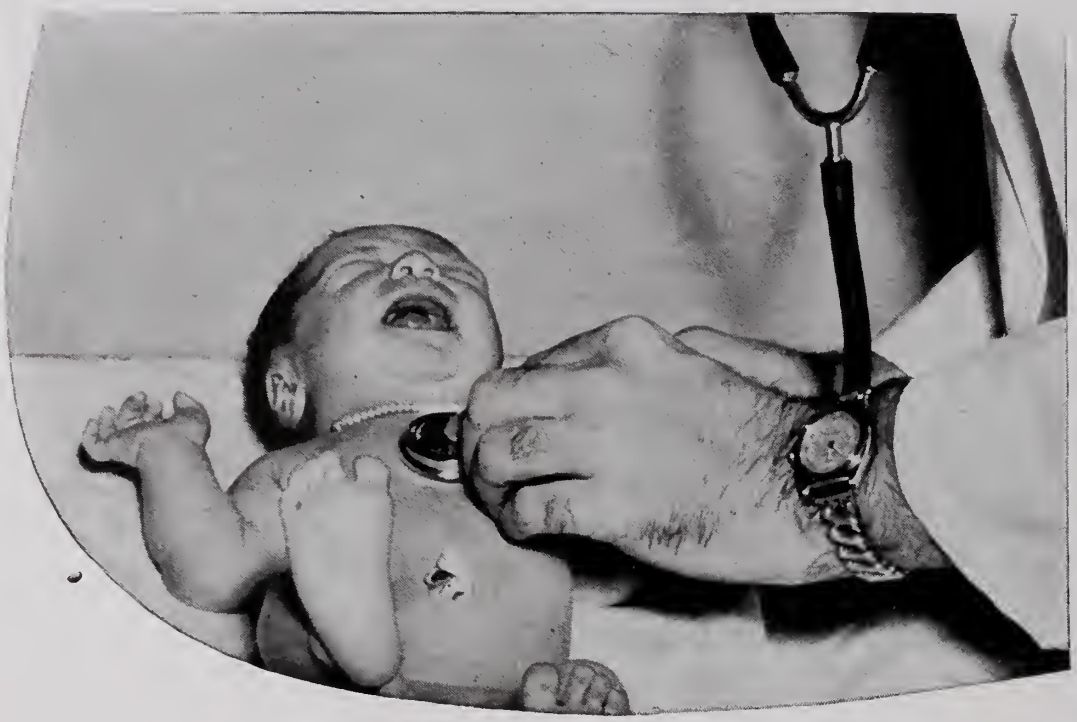
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HEALTH IN PROVIDENCE IN 1947

Below is the preliminary report of the Superintendent of Health and City Registrar for the year 1947.

During the year 1947 there were 97 more deaths and 975 more births than in 1946. The rates as shown have been figured at a population figure of 266,000 rather than at the federal estimate which is somewhat higher.

It is interesting to note that the increase in the number of deaths from heart disease during the year 1947 over that of 1946 equals the increase in deaths in the age group over 70. This figure also accounts for 90% of the total increase in the deaths over the previous year.

While there was an increase in the number of infant deaths in 1947, the Infant Mortality rate shows a decrease over the previous year. This is accounted for by the marked increase in the total number of births.

The 1946 epidemic of measles and whooping cough continued on through 1947. We were exceptionally fortunate in having had only one death from measles during this entire period. We were also fortunate in having no resident deaths from Poliomyelitis among the 46 cases reported.

The incidence of Diphtheria is on the increase. It must be remembered that owing to the contracting world many persons returning from Europe are bringing back with them the diphtheria organism. Because of the comparative freedom from this disease, there has been a certain laxity on the part of parents in having their children properly immunized and tested. It is absolutely vital that parents become conscious of the fact that only by reschicking can they be sure that their children are still protected against this disease.

It is also gratifying to note that the downward trend of the incidence of Tuberculosis has continued for the year 1947. However, it must be realized that constant care and vigilance must still be exercised against this disease to prevent a change in this trend.

During December the Health Department recodified its regulations regarding restaurants and other eating and drinking establishments, to comply more closely with the standard Federal Ordinance.

During the year 1947 this Department also set up a Rat Control program.

April 1, 1948

MICHAEL J. NESTOR, M.D.
Superintendent of Health

PRELIMINARY REPORT OF HEALTH DEPARTMENT STATISTICS
PROVIDENCE • RHODE ISLAND
1947

	1947	1946	1945
VITAL STATISTICS			
Deaths all	3270	3173	3158
Deaths under 1	281	269	227
Deaths over 70	1246	1157	1120
Births	11190	10215	8232
Marriages	3525	3903	2814
Infant Mortality	25.11	26.33	27.57
Death Rate	12.29	11.92	11.91
Birth Rate	42.06	38.40	31.06
PRINCIPAL CAUSES			
1. Heart Disease	1143	1054	1082
2. Cancer	486	484	446
3. Pneumonia	106	108	115
4. Nephritis	179	182	188
5. Cerebral Hemorrhage	201	216	224
6. Auto Accidents	40	49	41
MILK DEPARTMENT			
No. Samples Tested	17686	16873	22373
No. Licenses Issued	1464	1389	1329
PHYSICIANS			
No. Visits to Sick Poor	309	986	1788

	1947	1946	1945
DIPHTHERIA IMMUNIZATION			
No. Schick Tests	7879	7217	7084
No. Alum Toxoid Treat.	4538	4394	4715
SMALLPOX IMMUNIZATION			
No. Vaccinated	1684	2208	2512
INSPECTORS			
Food Inspector:			
Inspections	7190	9041	8687
Licenses Renewed	1940	1917	1779
New Licenses	215	210	92
Transfers	177	150	131
Licenses Withdrawn	2	0	1
Licenses Not Approved	17	5	0
Lunch Cart Licenses	3		
Sanitary Division:			
No. of Visits	6795	6225	7524
Animal Bite Visits	1816	1461	1248
Kennel Lic. Approved	39	36	78
Garbage Lic. Approved	19	12	21
NURSING VISITS			
Communicable Diseases	6775	6288	4626
Parochial Schools	3890	4662	3200
Tuberculosis—Home	9022	7466	4958

COMMUNICABLE DISEASES	CASES				*DEATHS*			
	1947		1946		1947		1946	
	Res.	Non-Res.	Res.	Non-Res.	Res.	Non-Res.	Res.	Non-Res.
Diphtheria	18	9	11	10	2	2	0	1
Scarlet Fever	176	78	186	56	0	0	0	0
Measles	2951	62	1079	14	1	1	0	0
Whooping Cough	842	38	1097	26	0	0	2	1
Pulmonary Tuberculosis	223		180		43	12	51	8
Septic Sore Throat	3	0	1	0	1	0	0	0
Strep Sore Throat	8	0	36	3	0	0	1	1
Gastro Enteritis	39	23	26	14	0	0	5	2
Bacillary Dysentery	7	0	7	0	6	4	0	0
Poliomyelitis	46	79	9	79	0	4	0	5
Epidemic Meningitis	7	11	12	17	1	2	3	4
Typhoid Fever	3	1	0	1	0	1	0	0
Paratyphoid Fever	3	3	3	3	0	1	0	0
Epidemic Encephalitis	0	1	0	0	0	1	0	0
Undulant Fever	0	0	1	2	0	0	0	0
Infectious Mononucleosis	9	2	4	1	0	0	0	0
Trachinosis	5	4	12	7	0	0	0	0
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Dr. Howard is a graduate of Harvard College and Boston University Medical School (1936), and the Harvard School of Public Health (1941).

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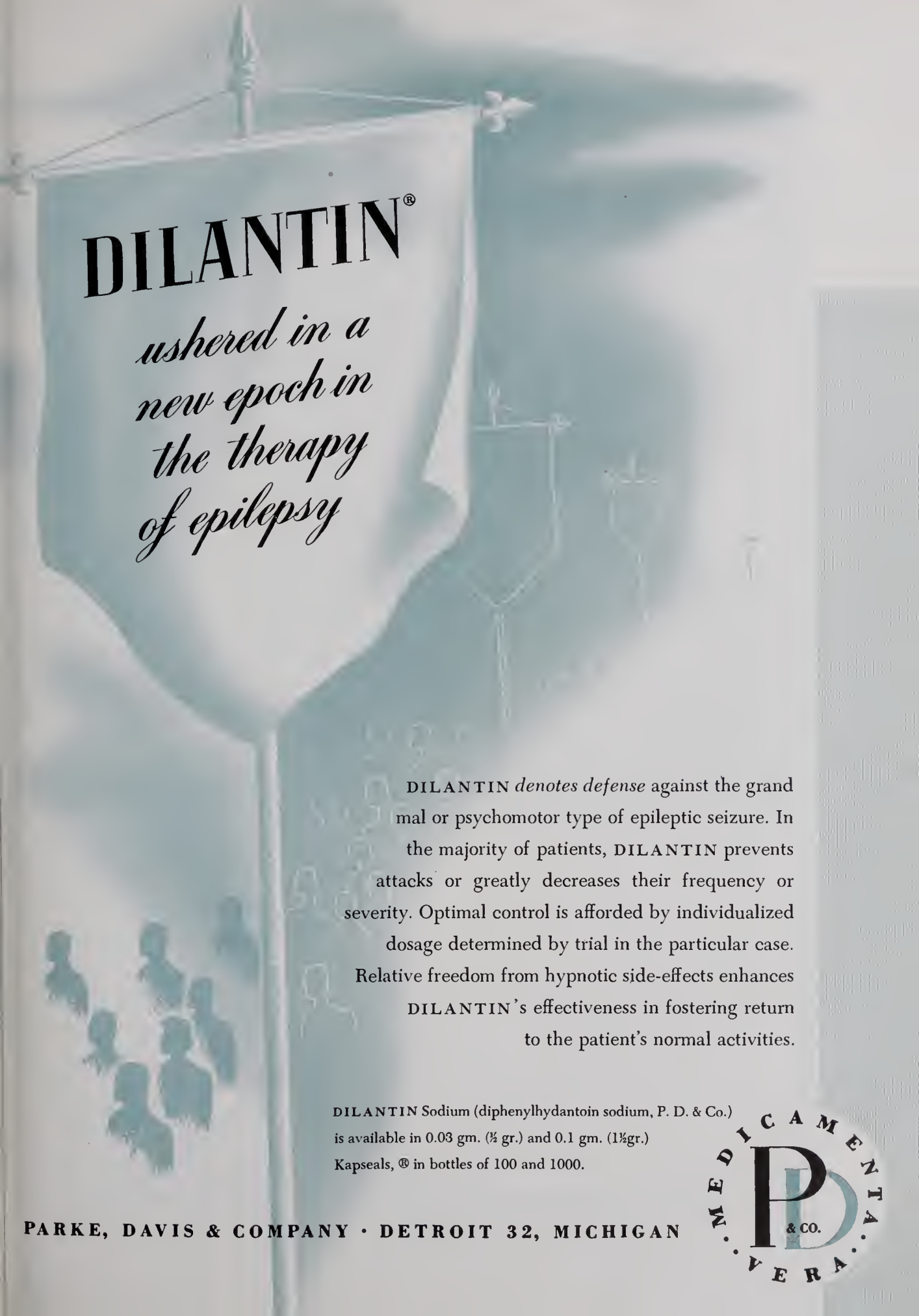
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INDEX OF ADVERTISERS

	PAGE
Abbott Laboratories	341
Alkalol Company	340
Ames Company, Inc.	328, 329
E. P. Anthony, Inc.	340
Ar-Ex Cosmetics, Inc.	337
Arlington Chemical Company	317
Ayerst, McKenna & Harrison	279
Bayview Convalescent Home	348
Blanding & Blanding	290
Borden Company	321
J. E. Brennan & Company	346
George A. Breon and Company	Inside front cover
Joseph Brown Company	346
Buffington's, Inc.	287
Burroughs Wellcome & Co., Inc.	344
Butterfield Drug Stores	346
Camel	336
S. H. Camp Company	288
Ciba Pharmaceutical Products, Inc.	277
Curran and Burton	348
Edgewood Junior College	Inside front cover
J. E. Hanger, Inc.	337
Hillcrest, Inc.	340
H. P. Hood & Sons	315
Langlais Health Institute	340
Eli Lilly & Company	Insert between 290-291
McCaffrey, Inc.	346
S. E. Massengill Company	289
Mead Johnson & Company	Back cover
Medical Milk Commission	327
A. B. Munroe Dairy	343
Mutual Benefit Health and Accident Association	278
Neland Pharmaceutical, Inc.	334
Nestle's Milk Products, Inc.	331
Owens-Corning Fiberglas Corp.	339
Parke, Davis & Co.	281, Inside back cover
Philip Morris & Company	280
Physicians Directory	286, 287
Rexall Drug Company	330
Rhode Island Limb Company	334
Schering Corporation	323
G. D. Searle & Company	313
Sharp & Dohme, Inc.	319
Smith-Holden, Inc.	282
Smith, Kline & French Laboratories	333
E. R. Squibb & Son	285
Strand Optical Company	348
Tilden-Thurber	316
The Upjohn Company	347
White Rock Bottling Company of Rhode Island	316
Winthrop-Stearns, Inc.	342



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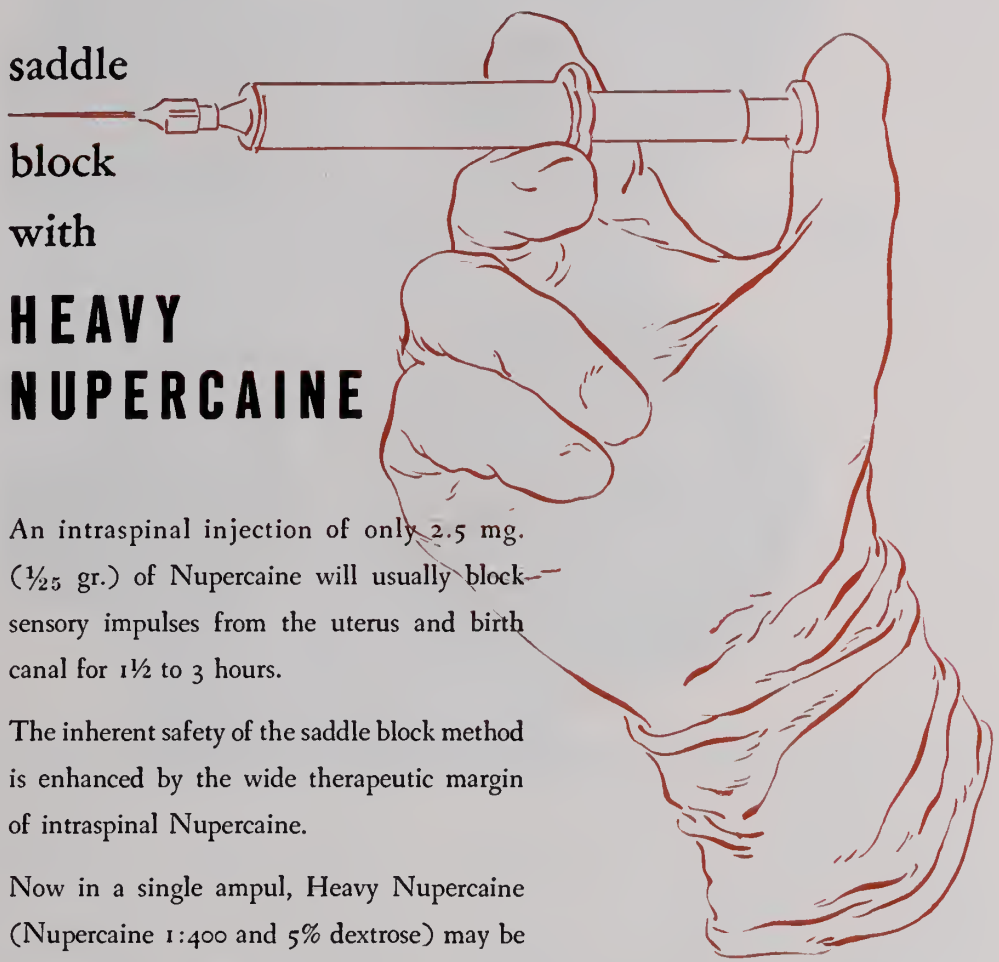
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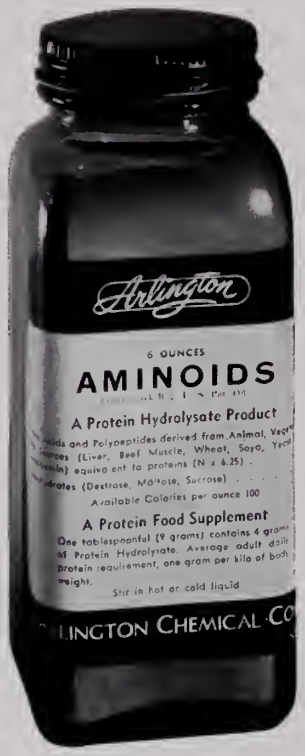
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TABLE OF CONTENTS

PAGE

Extra-Mural and Intra-Mural Practice—Then and Now, *Samuel A Levine,* M.D. 363
Medical Leadership, *Presidential Address, Arthur H. Ruggles,* M.D. 369
Profound Prerenal Azotemia Resulting From Pyloric Stenosis, Report of Case, *Aaron T. Beck,* M.D. 372
Proposed Draft of Physicians, Report of Bureau of Legal Medicine of the AMA 382
In the Event of a National Emergency 401

EDITORIALS

Navy Pollution in Narragansett Bay 375
What's Wrong With the Profit Motive 376

DEPARTMENTS

Appointed Committees, 1948, R. I. Medical Society 410
Book Reviews 412
Child Health Services Study by American Academy of Pediatrics 411
District Medical Society Meetings 397
Health Insurance Committee Report 378
House of Delegates, Report of May 5, 1948 Meeting 388
Woman's Auxiliary 407

MISCELLANEOUS

Index of Advertisers 409
Record Librarians Elect 409

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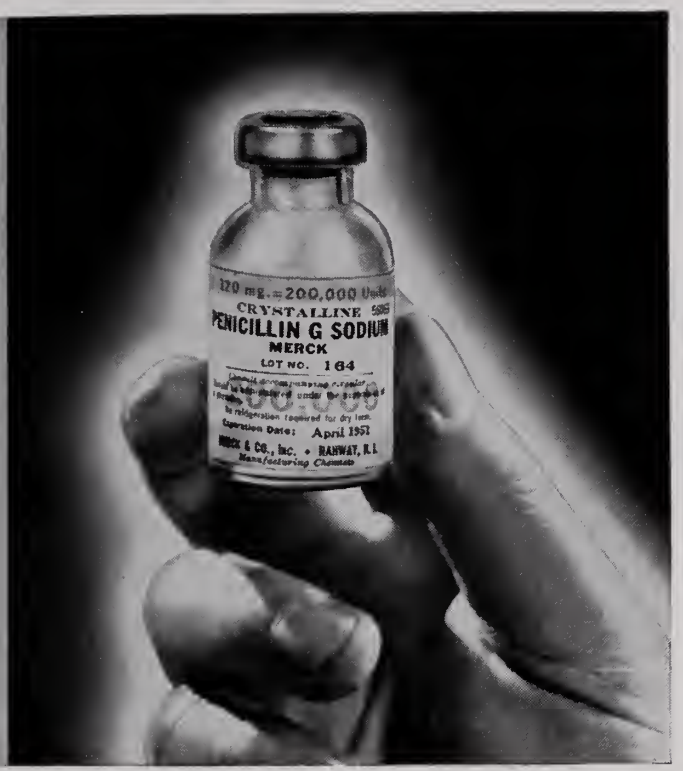
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"IT IS TO THE HINDUS that we owe the first system of medicine," states Wise. Other Western scholars have indicated that the Greeks are indebted to the ancient Hindus for the growth and development of medical knowledge. Since modern Western medicine is principally based on the Greek system, we are indirectly dependent, in some particulars, upon Indian medicine and surgery.

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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXI JUNE, 1948 NO. 6

EXTRA-MURAL AND INTRA-MURAL PRACTICE—THEN AND NOW*

SAMUEL A. LEVINE, M.D.

The Author. *Samuel A. Levine, M.D. of Boston, Mass. Physician, Peter Bent Brigham Hospital; Assistant Professor of Medicine, Harvard University Medical School.*

MR. PRESIDENT, Members of the Providence Medical Association and Friends — I chose a rather odd title for my talk tonight. It is a sort of noncommittal subject that gives me plenty of leeway to ramble. This is the hundredth year celebration of your society, and it gives us an opportunity to look back on an entire century. You can quickly see what a difference there is between the role of the practitioner then and now. About all he could do one hundred years ago he could very well do at his office or in the patient's home. Very little was lost as far as the welfare of the patient was concerned if he overlooked many of the conditions that were then prevalent. Just think of how that has all changed now.

To obtain some picture as to what was going on in 1848, I looked over some of the issues of the Boston Medical and Surgical Journal of that year. As you can quickly guess, the articles concentrated their attention on infectious diseases, midwifery and a great variety of drugs and bizarre therapeutic procedures. Just about this time ether was discovered and that began to attract attention. In the first issue of that year there was an article on "Rattlesnakes" and the various treatments employed for snake poison. All sorts of concoctions were used; decoction of viola ovata, juice of purple bind weed, olive oil externally and internally. In another article on Typhus Fever by Dr. Silas Brown the author states that 'blistering the arms nigh to the shoulder is superior to my old custom of blistering the scalp". Although we still have no specific treatment for typhus or typhoid fever, we at least know what not to do. Another paper was published by Daniel Holt, M.D. and R. Stackford, M.D., entitled "The Dysentery as it Appeared in Lowell in 1847, Homeopathically Treated". A great variety of medicaments was employed, one type for one stage of the dysentary and another for a different stage. Amongst the drugs mentioned were aconite, colocynth, mercury, nux vomica, arsenic and rhus toxicodendron. Then there was an article on "Etherization" and another on "Clinical Records and Post-Mortem Illustration of Typhus or Ship Fever". Ship fever was a mixture of typhoid and typhus fever, for both were prevalent in New England one hundred years ago and the two were not clearly differentiated until later. A paper by Dr. S. Clapp of Pawtucket also appeared "On the Pathology of Diabetes Mellitus" in which he claimed it was due to a disease of the brain. Then there were articles such as "Etherization in Labor" and "A Case of Labor, Complicated with Cervical Presentation and Uterine Tumor", discussing how that was managed.

The point of all this is that with the knowledge available at that time the physician could do everything he could, either in his office or in the patient's home. The main purpose of a hospital was to isolate infectious cases, especially smallpox, and to serve as an almshouse for the very poor. There were no special examinations or therapeutic procedures that could be done there that could not be performed at home. The situation obviously is entirely different at the present time, with the result that hospital space is required more and more for additional work to be done, either diagnostic or therapeutic. The situation is not likely to lighten, as the demand for more involved observation and methods of treatment is more apt to increase as time goes on.

With the great increase in medical knowledge that has taken place these past decades, the function and responsibility of the physician has changed. It now often matters greatly whether the family practitioner, who is generally the first one to meet the medical problem, overlooks the underlying

continued on next page

*Presented at the 101st Annual Meeting of the Providence Medical Association, at Providence, R. I., January 5, 1948.

cause of the illness. He has the most difficult task, for he needs to guide the patient along the right path for further investigation. He must choose what test to perform or from what specialist to seek further guidance. His training may leave him bewildered, for he learned in his internship days that the possibilities involved in many cases are numerous. The early habits that he developed were those prevalent in intra-mural practice. Now he needs an entirely different point of view, one that is suitable to extra-mural practice.

During the years spent in hospital training, the young physician learns a good deal about an extensive differential diagnosis. An obscure case is admitted and quickly several possibilities come to his mind. Within a few days the Wassermann test is found to be negative which rules out syphilis. An X-ray of the chest is done and found to be normal, which eliminates tuberculosis and tumor of the lung. Various blood and urine examinations are performed, as a result of which leukemia, polycythemia, uremia, diabetes and other conditions can be dismissed. Finally, the blood culture report is returned, and found to be positive for streptococcus viridans and the diagnosis of sub-acute bacterial endocarditis is made. In fact, many of these tests are routine in most teaching hospitals so that the physician does not even have to think about these possible diagnoses. How different the situation is when you go into practice, especially in general practice! You can not turn around and ask what the blood counts were or what the X-ray of chest showed or what the lumbar puncture revealed. You only have your five senses and a few simple instruments that you carry in your bag. An entirely different type of thinking is now necessary. In some ways the early intra-mural or hospital training may actually be a handicap. There are many diagnoses that are automatically made or eliminated in hospital practice. The young interne or the senior staff member cannot overlook conditions like diabetes, leukemia, polycythemia and many others because the routine tests done the first day or two quickly supply data to answer these questions. The result is that one does not even have to think about many of these possibilities.

When the physician continues his work in extra-mural practice and is left on his own resources, he now has to think particularly of those conditions which his more restricted routine does not cover. He no longer performs a Wassermann test on every new patient or examines the fundi or counts the blood corpuscles. He now must choose which of an endless variety of examinations he should perform. He cannot do all of them, for much time and money would be wasted. After formulating a reasonable procedure for every new patient, which might well include a routine examination of the urine, a determination of the blood pressure, in addition to an adequate family history, past history, present illness and physical examination, the busy practitioner needs simple clues to guide him for further study or treatment. Additional study may not be necessary when the problem is simple. When an elderly patient is suddenly stricken with a hemiplegia and is found to have a blood pressure of 220/110, there is very little doubt but that he suffered a cerebral hemorrhage or thrombosis. However, if the same hemiplegia occurred in a young woman 35 years old, who had a blood pressure of 125/85, he would listen to the heart with greater care and possibly find evidence of mitral stenosis and conclude that cerebral embolism had occurred.

The great difficulty centers around those cases in which the preliminary survey fails to reveal an adequate diagnosis. The general practictioner has the most difficult task of all physicians. He must discover the one patient out of a thousand he sees who has a brain tumor, or pernicious anemia; the one in a hundred who has pulmonary tuberculosis; the rare case of coarctation of the aorta, as well as the more common patient with acute appendicitis, cancer of the bowel or streptococcus sore throat. It was not difficult for the late Dr. Harvey Cushing to make the diagnosis of brain tumor in most cases, for his patients were sent to him with that diagnosis already suspected. It was the function of that great master to confirm the diagnosis and perform the delicate task of curing the malady if it were possible. As was stated above, the really difficult job is for the physician in the field, so to speak, to find or suspect the case to begin with.

The following experience illustrates the change in the type of thinking required in general extra-mural practice from what often prevails within the confines of hospital practice. A woman sixty years old complained of some vague cerebral symptoms and had weakness of one arm. She was seen by two experienced consultants who did most of their work in teaching hospitals. Both agreed with the family physician that the patient was suffering from cerebral arteriosclerosis. By an odd chance I had an opportunity of seeing this case, and arrived at the same conclusion. However, I did suggest that there were several other possibilities that had not been ruled out by the limited examinations carried out in the patient's home. If she had been in a hospital, she would have had routine blood counts, a Wasserman test, X-ray of the skull and lumbar puncture. Some of the conditions upon which these procedures could throw light obviously had not been eliminated. I therefore advised searching for the possibility of luetic infection, brain tumor and polycythemia. As it turned out, the erythrocyte count proved to be 8.5 million and the diagnosis

of polycythemia vera was established. The point of this experience is that the correct diagnosis was made, not because I knew more than the other consultants about polycythemia. In fact, this was the first case I had recognized in private practice and this patient had been seen by a consultant who had written one of the best treatises on the subject. The difference was that the intra-mural physician never had to think about making the diagnosis of polycythemia. It was always made for him by the laboratory intern. Whereas I was aware of my limitations and realized that, in general practice, one had to think about those conditions that a very restricted routine examination did not include. We particularly need to think about those diseases which are amenable to medical or surgical treatment, and from which spontaneous recovery does not take place.

What is the physician to do when he sees his patient in the office or in the home? Which one of the innumerable tests should he employ? He cannot do all of them every time he sees a new patient. It would simplify matters greatly if the important ones could be as quickly and inexpensively performed as the Benedict test for sugar. Then we might well obtain a routine X-ray of the chest and gastro-intestinal tract, a complete blood examination, a metabolism determination, an electrocardiograph tracing, etc., in all cases. The diagnosis of diabetes is not often overlooked, or one might say should not often be overlooked, because the diagnostic test is so simple. But many conditions require more time and elaborate techniques for their analyses, and the physician needs some clue as to which he should perform. There are many such clues available, and the experienced clinician is constantly using this method consciously or subconsciously. After constructing an extensive differential diagnoses for a certain set of clinical circumstances, a process one learns particularly in hospital training, he now is confronted with the problem of eliminating one condition or another — or what might be called the "destructive differential diagnosis." In intra-mural practice, one possibility after another is eliminated by certain tests. In extra-mural practice the physician would like to perform the right test first or soon, as he fears he will not be able to perform them all. He needs simple bedside guides to enable him to dismiss some of the possible diagnosis from consideration, to spare the patient the trouble and expense of additional laboratory procedures. Instead of doing a Wasserman test that rules out syphilis, an X-ray that rules out tuberculosis, a blood culture that rules out bacterial endocarditis, and finally a basal metabolism determination that establishes the diagnosis of thyrotoxicosis, he would wish to perform that last test first.

There is great need, therefore, for simple means to rule out diagnoses as well as to rule them in. This entails the use of short cuts, which need not be absolutely accurate, but which enable the physician to be guided more quickly to the correct diagnosis. This method of medical thinking is sometimes frowned upon because it is not scientific, but I am certain that it is very helpful and useful, especially for the active, busy practitioner or consultant. All experienced physicians constantly employ this method, but very little is formally taught about it. Let me illustrate. Frequently the possibility of hyperthyroidism comes up when there has been loss of weight, weakness, shortness of breath, and some other vague signs or symptoms. We know that a basal metabolism test can answer the question. But if the patient prefers summer to winter and has a coarse dry skin, it is very unlikely that he has hyperthyroidism, and one would be justified in not performing the metabolism test at that time, and look for some other cause. On the other hand, if under the same circumstances, the patient preferred cold to warm weather and had a warm, moist skin, the metabolism determination might be the first test to do. In a very recent experience such simple bedside clues proved very decisive in a patient's recovery. This man had pain in the chest from coronary artery disease. The electrocardiograms definitely confirmed the diagnosis. He had been in bed for weeks with recurrent chest pain. When he was seen one cold morning (and his bedroom was also cold) he was covered with only one sheet and his feet were uncovered. When he was asked about this, he replied that for some years he had felt warm and did not like many bedclothes. That was enough to direct my attention at the thyroid gland. On careful palpation a small nodule was felt in one lobe, which had been overlooked and which one could readily miss unless it was deliberately looked for. He subsequently made a most gratifying recovery after a course of iodine therapy and a sub-total thyroidectomy.

Frequently in febrile illnesses the question of bacterial endocarditis and tuberculosis arises. One hundred years ago it did not matter whether the correct diagnosis was made. Now, with the availability of chemotherapeutic and other agents, it makes the difference between life and death. Here, also, a so-called short cut can be employed. If there has been prolonged fever, sweats and loss of weight and no murmurs whatever can be heard, blood cultures would be the last thing to obtain. Such a patient will almost never have bacterial endocarditis. By this simple bedside observation, one is justified in eliminating the diagnosis, and will more quickly look for tubercle bacilli in the sputum or gastric washings, or obtain an X-ray of the chest. In this way I have frequently been able to

continued on next page

rule out the diagnosis of subacute bacterial endocarditis (when it had been seriously entertained previously) even though I was unable to offer a more positive alternative diagnosis. There are many situations where it is vital at least to rule out a certain diagnosis, even if one cannot suggest the correct one. In the problem just discussed simple auscultation, which can be carried out by any physician in a few moments, may spare the patient the cost of several unnecessary blood cultures.

I have emphasized that the practitioner is mostly concerned with conditions that are amenable to treatment. In contrast, the investigator works on unsolved problems. As therapeutic procedures are discovered that are applicable to hitherto incurable conditions, the responsibility of the physician increases. A striking example of this is the surgical treatment of various forms of congenital heart disease. In the past it did not greatly matter what form of congenital defect was present, as there was no treatment available. Now that conditions like patent ductus arteriosus or coarctation of the aorta can be cured, it is imperative that correct diagnoses be made. Let us apply the principles discussed above to the new situation that confronts the general practitioner with regard to some of the problems of congenital heart disease. In order to discover cases of coarctation of the aorta, it is necessary to think of it in every patient with hypertension. As a further aid, it should become the routine habit for the physician to palpate the femoral arteries and abdominal aorta in every case of hypertension. If these pulsations appear normal and vigorous, one can fairly safely rule out coarctation of the aorta. If they are difficult to feel or entirely absent, the possibility of coarctation of the aorta is great, and then further tests need to be made to confirm the diagnosis, i.e., a lower blood pressure in the legs than in the arms, the presence of pulsating arteries near the scapulae, and notching of the ribs on X-ray examination. Inasmuch as it would be a great waste of time and effort to go through these additional procedures in all hypertensives, the simple bedside technique of finding adequate femoral pulsations limits this search to those who are most likely to have the condition under consideration. This is another instance in which a simple test can rule out a particular diagnosis, for the finding of a strong femoral pulse fairly well eliminates the possibility of coarctation of the aorta.

Angina pectoris is another example in which the diagnosis can generally be ruled out by simple means. All the physician needs to do is to ask one question. No expensive tests or elaborate methods of examination are necessary. If the patient can walk briskly in cold weather without stopping and without experiencing pain or distress in the chest, one can be fairly certain that he is not suffering from angina. This does not apply to the diagnosis of coronary thrombosis, which often occurs at rest. Nor does the absence of chest distress on walking briskly eliminate the possibility of a previous attack of coronary thrombosis, for many patients have no physical limitations after such attacks. The point is that complete freedom in walking briskly, after meals, in cold weather and up grade, means that he has not angina at that time, and whatever symptoms such a patient might have are probably due to some other cause.

While considering angina pectoris and coronary artery disease, it is of interest to comment on the differences in the two sexes with relation to hypertension. Whereas angina is very common in men who never had hypertension, it is quite rare in nonhypertensive women, especially under the age of 55 to 60 years. If a woman has symptoms suggesting coronary artery disease and is known to have had a normal or low blood pressure all her life, it is well to look for some other cause. In such cases X-ray of the gall bladder looking for stones, of the spine for arthritis, of the gastro-intestinal tract for diaphragmatic hernia or other pathology, all are indicated and may reveal the true nature of the illness. Not long ago an obese woman 45 years old from this city came to see me. She had been in a hospital for several weeks and treated for acute coronary thrombosis. She had been taken with severe distress in the lower sternum and upper epigastrium, and during her hospital stay also developed heart block. The latter complication seemed to confirm the diagnosis. I learned that she never had hypertension and that the heart block followed liberal administration of digitalis. The absence of hypertension made me suspect that she did not have coronary artery disease, and X-ray examination showed a fairly large diaphragmatic hernia of the stomach. There was no evidence of heart disease, and subsequent events confirmed the fact that the stomach was the cause of her difficulty. One must admit that women do have coronary disease without hypertension, but it is comparatively rare. This general viewpoint merely directs attention to other possibilities that need investigation in certain cases that otherwise would be overlooked.

The appearance of the tongue is another simple clue that will aid the physician in diagnoses and help to eliminate certain possibilities. When a middled-aged or elderly patient is seen who is anemic, the possibility of pernicious anemia must always be considered. This condition must particularly be thought of because it is curable. If the tongue is dirty, coated and furrowed, one can readily dismiss pernicious anemia from mind. Contrariwise, if an anemic patient had been chronically

ill, possibly bedridden, and still shows a clean, smooth, somewhat glossy tongue that is likely to be less pale than the skin, the possibility of pernicious anemia is so great that all effort should be made to establish the diagnosis, e.g., gastric analysis, blood counts, etc. This simple observation of the tongue that only takes a few seconds has enabled me to make the diagnosis of primary anemia on several occasions, when patients were being unsuccessfully treated for chronic heart disease. In such cases the entire outlook would change and the patient would be completely rehabilitated, primarily as a result of observation of the tongue.

When the possibility of uremia comes up, there are also simple tests which any physician can perform that may help at least to rule out the diagnosis. If a patient is apathetic and drowsy and full-blooded, it is extremely unlikely that uremia is the cause. One does not see advanced chronic nephritis with uremia in a patient with a hemoglobin of 100%. This test can be performed readily, whereas the blood urea nitrogen determination is much more elaborate. Furthermore, the specific gravity of the urine may be very informing in such a case. If the specific gravity is 1020-25 or more, it is extremely unlikely that the patient has uremia. These again are so-called diagnostic short-cuts. They are helpful to "rule out" diagnoses even if they do not establish the correct diagnosis.

Nowadays we have to keep in mind rare conditions that are amenable to treatment or to cure. Amongst these is Addison's disease. As has been stated above, every therapeutic discovery brings a new challenge and responsibility to the physician. Previously Addison's disease was fatal; now it can be controlled and patients enabled to live long and useful lives. If this diagnosis comes up for consideration, the finding of even slight enlargement of the heart is a reliable sign that Addison's disease is not present. With adrenal insufficiency the heart is smaller than normal, not larger than normal. This does not mean that all patients with small hearts have Addison's disease, but it does mean that practically no patient with an enlarged heart has Addison's disease.

Physicians too often send patients to hospitals for diagnosis when simple examination in the office or the home should have been adequate. The diagnosis of angina pectoris in the great majority of cases can be made after an intelligent appraisal of the symptoms and little additional useful information will be acquired by elaborate hospital study. The same is true of the diagnosis of mitral stenosis. If, on careful auscultation, the diagnostic signs of mitral stenosis are detected, it will not help materially to know whether the heart is slightly or moderately enlarged or whether the electrocardiograms show right or left axis deviation. This does not mean that there are not circumstances under which hospitalization may be profitable. There may be certain aspects of treatment, such as thoracentesis, that can better be carried out there. Additional diagnostic study may be indicated in certain cases, such as repeated blood cultures for a suspected bacterial endocarditis. However, the anatomical diagnosis of mitral stenosis, per se, rarely requires hospital study. It is mainly when there is doubt concerning the diagnosis that hospitalization is necessary. In this regard, the more intelligent use the physician makes of the simple methods of examination that require no more than what he carries in his head and in his bag, the less he will need the hospital.

The hospital is, therefore, needed when diagnosis is obscure and simple diagnostic procedures are inadequate. There various elaborate tests can be performed, and it taxes the wisdom of the physician to select those tests which are most likely to reveal the underlying cause or nature of the disease. A striking example of the usefulness of hospital study where the diagnosis was obscure is the following experience. Several years ago I saw a man about 20 years old who had been blue since birth. He had been regarded as having some form of congenital heart disease. I was unable to find any abnormalities of the heart on physical examination, and fluoroscopic and electrocardiographic examinations were also normal. Although he was markedly cyanotic, he did not have clubbing of the fingers. I sent him into the Peter Bent Brigham Hospital for study. There our resident physician (Dr. C. B. Favour) quickly withdrew some venous blood and bubbled oxygen through it. He observed that the blood remained blue instead of becoming red, as it normally should. From this he concluded that the case was one of congenital methemoglobinemia and not congenital heart disease. This diagnosis was subsequently confirmed by chemical and spectroscopic study. As a dramatic climax, within 30 minutes after giving this patient methelene blue, his color was normal for the first time in his life. This experience is recorded to illustrate the usefulness of hospitalization when the diagnosis is obscure.

The hospital is also needed to carry out certain care, medical or surgical, that cannot be performed adequately or at all at home. The need for hospitals has increased greatly in recent years, and is likely to continue to increase. With every new advance of technology, new methods of study and treatment become available. To mention congenital heart disease again, now that surgical treatment is available, more and more cases will have to be studied by catheterization of the heart. This is a very involved and elaborate, though riskless, procedure. It requires hours of work on the part of

continued on next page

many people, and yet it is indispensable for accurate diagnosis in some cases. This is merely one example to illustrate that the need for hospital space is increasing. It also illustrates why the cost of medical care will keep on increasing. There is more the physician can do to improve health. He now will want to go to a great deal of trouble to establish the diagnosis of patent ductus arteriosus, and then to have it cured surgically.

With each new therapeutic discovery we are compelled to look more diligently for those cases that might be helped by the new treatment. Until the present time, the diagnosis of cancer of the pancreas has been more a matter of academic interest than one of value to the patient. It may not be very distant when the situation will be changed. Attempts are being made at radical surgical cure of cancer of the pancreas. If this attains any real success, the diagnostic problems will increase tremendously, for it will then be necessary to investigate patients in hospitals very elaborately to detect early cases. This will obviously increase the need for hospital beds and the cost of medical care.

In this general discourse concerning extra and intra-mural practice which, as you see, has taken us into many fields, there are some useful habits or mental attitudes that are worth discussing. It is best for physicians to develop these habits early in practice, for then they serve their useful purpose reflexly, so to speak, and are not forgotten. It is well for a physician, on leaving the bedside of any patient who is seriously sick or not progressing favorably, to keep asking himself, "What further might I do that would help therapeutically or diagnostically?" "What may I be overlooking?" These questions should keep recurring in his mind long after he has left that patient, while he is driving his motor car or while walking to the theatre. "Has that patient who is gasping for breath one or two liters of fluid in the chest that can be removed? Did the diuresis that was expected accumulate in the bladder?" I recall finding 1500 cc. of urine in the bladder postmortem in such a patient I treated. It would have been a simple matter to catheterize this particular unconscious patient, and he might have been helped, had I not overlooked the full bladder.

It is important to think constantly of those conditions, even if rare, that are curable. I recall an early case of so-called arthritis of the spine which had disabled a particular man for 18 months. X-ray examination even showed some arthritic changes in the upper dorsal region. Only later did a more astute observer perform a lumbar puncture and establish the diagnosis of cord tumor. This proved to be an enucleable tumor, as they often are in the spinal cord, and the patient was completely cured. This costly experience proved valuable to me in later years, as it enabled me to detect similar cases that I am sure I would otherwise have overlooked. The inference from such experiences is that it is more important to think of rare diseases that are curable and that do not spontaneously disappear, than the more common ones that are not curable or which do well with symptomatic treatment.

There are particular diagnoses which not infrequently are incorrect. A good example of this is multiple sclerosis. I have seen two instances in which competent neurologists made the diagnosis of multiple sclerosis, where subsequent study revealed a curable cord tumor. The same eventual diagnosis was made in isolated cases incorrectly diagnosed amyotrophic lateral sclerosis and combined system disease. It is well to rule out the possibility of cord tumor by any reasonable means in any disabling neurological condition affecting the spine, if there is no definite involvement of the brain or cranial nerves. Obviously, if the brain is involved as well as the spinal cord, the diagnosis cannot be cord tumor, and must be a more general and widespread lesion. I mention these neurological conditions, although they are somewhat beyond my common interest, because I have had the opportunity of making such correct diagnoses of spinal cord tumor when neurologists have been wrong. It was not because I was more familiar with the problems of neurology that I reached the correct diagnosis. It was rather because I knew less of neurology, but realized my limitations and was more concerned with the general principle of looking for curable disease than were my neurological colleagues.

There is another habit of mind or mode of thinking which physicians will find useful. There are combinations of symptoms or signs that often go together. Mitral stenosis, auricular fibrillation and a past history of rheumatic fever often are found in the same individual. If you find two of this triad, look for the third. If a patient with a past history of rheumatic fever later is found to have auricular fibrillation, he very likely has mitral stenosis, whether you can hear the diastolic murmur or not. Likewise, if a rheumatic with mitral stenosis develops an apparently very irregular rhythm, it is most likely auricular fibrillation. Another combination is gallop rhythm, bundle branch block and pulsus alternans. If two of the triad are present, it is well to look for the third. Similarly the triad of renal stones, limb pains and parathyroid adenoma may be helpful to enable the physicians to think about these rare but curable cases of tumor of the parathyroid. Also diabetics at the age of 50 to 60 years so frequently have coronary artery disease and gall stones that this combination of conditions should be kept in mind.

continued on page 371

MEDICAL LEADERSHIP*

ARTHUR H. RUGGLES, M.D.

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LAST YEAR Dr. Pitts, your retiring president, in his address set an excellent example of brevity and wisdom. I shall follow his example in brevity and only wish I might approach his wisdom.

The whole world seems to be in an unsettled and apprehensive state. As physicians we surely are in a position to help not only sick bodies but sick and uncertain minds. Even in our own profession we have seen reverberation of the world's uncertainty and tension. The medical profession for a long period of time has been so busy and so absorbed in its own mission of trying to prevent disease, and its duties in the care of the sick, and in its ever continuing research studies, that we have had very little time to devote to the broad social, economic and spiritual problems of our communities. To me it is very remarkable that so many busy physicians have been able to contribute as much as they have in their efforts in community betterment and many other types of public service. More especially in recent years the sum total of medical knowledge has steadily increased. The demands made upon the general practitioner and more particularly the specialist are constantly increased. Like all professions, in fact as in all walks of life, we cannot stand still, we must either go ahead or slip back. Thus the demands upon our time constantly increase, and yet there are still only twenty-four hours in every day.

We have recently heard some criticism that on certain days and evenings of the week the average citizen has found it difficult to obtain medical services. Your Society has given heed to complaints of citizens, even though often upon investigation the complaints have been quite unfair and overdemanding. We have always wanted in Rhode Island, to give the very best possible professional service to all who need it, but again let me remind you that all work and no play would make the doctor a dull fellow, and as we look about us it is a rare doctor who works only forty-eight hours a week, while the rest of the world tries to impress us with the fact that they would be better off if they only worked forty.

In addition to performing their own daily tasks well, many members of our Society have, during the year, made very definite contributions in their efforts to lessen and prevent water and air pollution and we have made some worthwhile gains in this direction.

Our many committees have taken much time out from busy practices in order to carry out their committee responsibility in a variety of fields, especially our health plan insurance study committee, which for over a year now has devoted many hours of thinking, conferring and planning toward a prepaid insurance plan that will protect those in lower income brackets in meeting operative fees, which have been set by your Society, when surgery becomes necessary. The work of this committee has already led to prepaid surgical insurance being offered to many of our citizens at reasonable rates, and in doing this, members of your profession have been willing to accept extremely low fees. For the work and sacrifice of the members of our profession, the people of Rhode Island should be very grateful. I only wish that the Blue Cross might participate in this plan, so that competition would be wide open and that our citizens be offered a premium schedule based on the widest of competition. The success of the surgical plan has not yet been brilliant, but we are told by those of experience that a good deal of education must precede the wide-spread demand for such insurance, and that we must wait another six months before the full benefit of the present plan can be estimated. Now within the past few weeks a meeting of the representatives of the Associated Medical Care Plans Association, together with the Directors of Blue Cross Commissions and Directors and Trustees of American Hospital Plans, was held, and discussed a proposed merger of the AMCP and Blue Cross, and the development of a national insurance company. A meeting has been called for June 19th, at the headquarters of the American Medical Association, regarding this whole subject.

continued on next page

* *Presidential Address Delivered before the Rhode Island Medical Society at its 137th Annual Meeting, at Providence, May 13, 1948.*

As those members of the Society who have been in close touch with the surgical insurance plan realize, this is a very large, complicated and difficult problem to solve and will need long and careful thinking through if a strong, practical plan is to result.

Again this is a recent illustration of the need for medical leadership in the whole problem of the practice of medicine, as well as in the solution of medical economic problems.

We have discussed during the year the formation of a Rhode Island Health Council, which should build health planning on a state-wide basis in order that one part of our State might benefit by what has been learned in another area and so that we might form our plans on a mutually cooperative basis. It has been the thought of those interested in a Rhode Island Health Council, that such problems as tuberculosis, cancer, poliomyelitis, mental illness, the care of the aged sick, might be studied in rural and urban areas; that the provisions for the care of those illnesses needing to be hospitalized could be determined; the question of outpatient facilities studied and recommendations made on the basis of adequate health facilities, both public and private, for every resident in our State.

The recent failure to pass the bill for improved standards of medical examiners' service perhaps illustrates what a strong state-wide health council could have done in bringing pressure to bear upon the Legislature for modernizing a somewhat antiquated medical examiner system.

Members of the medical profession and those interested in health problems from the various social angles have met, and a committee appointed by your President is further studying the organization of a state-wide health council, which I sincerely hope may eventuate.

The Governor of our State has appointed a Hospital Advisory Commission to study and coordinate the hospital facilities of Rhode Island, with a view toward establishing priorities that would make federal funds available for new construction, and on this Commission there are three members of this Society. This Commission is given the responsibility of determining what added hospital facilities are needed in the State; what areas in the State are most efficient in hospital bed facilities; whether an increasing or decreasing number of beds is needed for different types of disease, and seeing to it that federal funds are not allocated unless such hospital construction is definitely needed, and upon the recommendation of such conditions, new hospital construction can come into being and the Federal Government will match every two local dollars with one dollar, toward such hospital construction. These indicated developments in our State are all evidence for need for coordinated planning, for plan financing and for seeing all the health needs of the State from a long-range point of view. The days of hit or miss study in the field of health are being replaced by state-wide studies, planning and development. In this the members of your Society will constantly be called upon for their leadership. It has recently been said by Dr. Edward L. Bortz, President of the American Medical Association, that, "leaderships in human relationships concerned with health and the control of disease, should come from the medical profession", and with this statement I am sure all members of the Rhode Island medical profession are in the heartiest of agreement.

It has been my privilege during the year to act as President of the Council of New England State Medical Societies, which has brought together officers and official representatives of the medical societies of all the New England states. One of these meetings was devoted to the extremely important topic of public relations. I think all the physicians in this group feel that such a Council set-up on a New England basis has been very valuable in the sharing of the many problems that are coming to the medical profession in these days of rapidly evolving social and medical change.

We also need to utilize our thinking and our influence in improving conditions in food handling and in promoting better laws and the enforcement of those laws for improved standards of milk. We need more time, personnel and opportunity for research problems in the fields of cancer, tuberculosis, mental illness and the diseases of old age.

Never has there been a time in the lives of any of us here present that has called for more careful thinking through of our problems and wise and constructive planning. The members of the medical profession have shown their willingness to give leadership, but must continue to do this in increasing amounts, which often presents real financial problems to the physician who has to give up so much time from practice in attending the necessary committee meetings, and yet I urge upon you that you take the necessary time to engage in the deliberations of our own Society and take a part in the organized committee work of the District and State Society.

We have during the year sent out a questionnaire to all our members, in order to determine whether they had time for committee assignments and on what committees they would like to serve. In this way we have found a number of doctors eager and able to serve on committees whom we had not been utilizing to the fullest extent. We hope if the load is widely spread, more interest in our Society's activities will be created and no one should be over-burdened with committee assignments.

Either the medical profession is going to continue to play the leading role in the development of better health for all our citizens, or else we have the ever-present threat of its being taken over by extremely well-meaning, often well-informed, but not medically trained individuals. We are members of an old and noble profession who have always risen to community or world needs whether in peace or in war, and I am sure that at this important time in the world's history we will not be found wanting. Through such leadership the advances in obstetrics, pediatrics, psychiatry, medicine and surgery, especially in neurosurgery, have been very great. In fact I know of no decade in history that has produced more beneficial knowledge to be applied to the prevention and cure of illness. Our citizens are living longer. The expectancy of life is steadily being prolonged and this has necessarily caused a tremendous problem in the care of aged people. Geriatrics has been thrust upon us and has already produced a magazine, various books and local and national organizations. Our profession must give thought to the physical and mental welfare of those who have reached the retirement age, and yet who have never learned to play. We must give further study to the deteriorating diseases and their prevention and treatment. Perhaps modern prostatectomy is one of the best illustrations of what advances can be made in the alleviation of deteriorating diseases and some of us are gradually learning that medical science has the relief for many other deteriorating diseases which, unaided, may lead to senile deterioration. For example: the restoration of eyesight by the removal of cataracts; the benefits obtained by hearing aids; the surgical cure of hernias; the support of the failing heart; proper diet and proper amounts of rest. These are just a few indications that very often so-called chronic conditions may not necessarily be entirely chronic. We must think through the problem of the cost of care of aged people and whether that is best arranged in connection with our special hospitals or in general hospitals, or by both means. We as a profession must see to it that if there is to be a new draft, with its consequent call upon many physicians, that such call be made in a carefully thought-out and planned manner, so that our medical schools, our hospitals and the care of the civilians is not interferred with too violently.

I have always enjoyed an expression of Wordsworth—"The shepherds stood on the hills guarding their flocks in calm contemplation." This is a time when we need more "calm contemplation" on the part of our profession toward the multitude of intricate and challenging problems that assail us on every side. At times it seems as if, perhaps, we had been doing a good deal of wishful thinking, with a tendency to let George do it, but at the present time both in short-term planning and planning as far into the future as one can forsee, we shall need all the professional leadership that we can command, and that leadership must think through our problems, determine the facts regarding them and must base both present and future plans upon this thinking and this fact-finding. It is only with the help of all of you that medicine can maintain its honored tradition and advance its leadership.

EXTRA-MURAL AND INTRA-MURAL PRACTICE—THEN AND NOW

concluded from page 368

In a word, the responsibility of the physician is perfectly tremendous nowadays as compared to 100 years ago. There was very little that he could have done when this society was founded in 1848, either in extra-mural or intra-mural practice. Now it matters greatly whether a profound anemia is due to metastatic cancer of the bones or to pernicious anemia. One hundred years ago a patient was not neglected if abdominal swelling and ascites was thought to be due to cirrhosis of the liver, when in fact it resulted from pericardial constriction. Now very little can be done for the former, but the latter may be cured. Then a murmur due to rheumatic aortic valvuluar disease could be confused with one due to patent ductus arteriosus without jeopardizing the health of the patient, for neither condition could be treated effectively. Now one of the two conditions can be rectified. One could continue almost indefinitely and enumerate many diseases that are now amenable to medical or surgical treatment which formerly were beyond our reach. All this impels us to utilize the various methods of study that are available, and particularly the simple bedside techniques that we all have readily at hand. In this way we will continue to merit the confidence of our patients, who entrust their health, the most precious asset they possess, to our care.

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PROFOUND PRERENAL AZOTEMIA RESULTING FROM PYLORIC STENOSIS*

Report of a Case With Postoperative Followup

AARON T. BECK, M.D.

The Author, *Aaron T. Beck, M.D., of Providence. Former Assistant Resident in Pathology, R. I. Hospital; now Assistant Resident in Neurology, Cushing General Hospital, Framingham, Massachusetts.*

PRERENAL AZOTEMIA, a state of renal insufficiency resulting from disease outside of the urinary tract, has been described in a wide variety of conditions. It has been observed in cases of prolonged vomiting caused by intestinal obstruction or the pernicious vomiting of pregnancy; in cases of severe diarrhea, such as occurs in Cholera; in cases of duodenal fistula; in diabetic coma; in the crisis of Addison's Disease; and in shock due to a host of causes, such as trauma, acute blood loss, and myocardial infarction.

REPORT OF CASE

FIRST ADMISSION — 7/27/42-8/1/42. A 42-year-old, white, single female was admitted on July 27, 1942 to the Medical Service of the Rhode Island Hospital with a Chief Complaint of intermittent vomiting. The patient had felt perfectly well until four months prior to admission when she began to vomit small amounts of recently ingested food and to experience gaseous eructations. There were no other gastrointestinal symptoms. A gastrointestinal series in the Outpatient Department one month prior to admission was reported to have shown pyloric obstruction. The duodenum had not been visualized.

Physical examination on admission was negative. Urinalysis revealed: specific gravity 1.018; albumin negative; spun sediment 10 white blood cells. The blood urea nitrogen was 5 mg. per cent. Gastrointestinal series showed a moderate amount of fasting free fluid present in the stomach. The rest of the gastrointestinal tract was not described. The patient was asymptomatic during her hosptal stay. The service felt that the vomiting might be psychic in origin. She was discharged, improved, on August 1, 1942. The discharge diagnosis was "Undiagnosed Disease."

SECOND ADMISSION — 10/25/45-11/14/45. The patient was readmitted to the Rhode Island Hospital on October 25, 1945 because of convulsions. Following her previous discharge, she had been perfectly well except for occasional vomiting. Three months prior to this admission, however, her vomiting began to recur every night and became progressively worse. Three days prior to admission she began to vomit everything she ate. The day of admission she experienced two generalized convulsions.

Physical examination revealed a well-developed, well-nourished female in a stuporous state. She showed occasional periods of Cheyne-Stokes breathing. The blood pressure was 120/80. The reflexes were generally hypoactive. The fundi were negative. The blood urea nitrogen was 73 mg. per cent and creatinine 4.9 mg. per cent. Urinalysis showed: protein 2 plus; sugar negative; sediment 5-8 white blood cells and 15 granular casts.

The patient experienced another generalized convulsion soon after her arrival on the ward. She appeared markedly dehydrated and was given 2000 c.c. of intravenous normal saline in the next twelve hours. A lumbar puncture showed a normal pressure, cell count and protein. Following intravenous fluids, the blood urea nitrogen dropped to 29 mg. per cent and the creatinine to 1.2 mg. Concomitantly she showed marked clinical improvement and became alert and rational. On November 2 hemoglobin was 13.7 gm.; white blood count 9,550 with a normal differential. Phenolsulfonphthalein test showed 65% excretion in two hours. Chest x-ray, barium enema and skull x-ray were negative. One week following admission the patient became asymptomatic and remained so during the rest of her hospital stay. It was felt on admission that this patient probably had an intracranial lesion in view of her convulsions, vomiting and coma. Laboratory tests and subsequent neurological examinations, however, failed to substantiate this. She was discharged on November 14, 1945 with the diagnosis of "gastric neurosis".

INTERVAL NOTE—11/15/45-4/23/46. Following her discharge from the Rhode Island Hospital, the patient continued to vomit every night and became increasingly drowsy and finally comatose. On January 7, 1946 she was admitted to the State Hospital for Mental Diseases. A physical examination at that time disclosed the patient lying

*Presented at a meeting of the Providence Medical Association, at Providence, March 1, 1948.

motionless and staring fixedly ahead. She showed no awareness of her environment and did not respond to spoken voice or manipulation of her body. Her pupils were pin point and did not react to light. Her blood pressure was 100/60. She showed marked dehydration and muscle rigidity. She remained in a stuporous state for four days during which time she received 2000 c.c. of 5% dextrose in saline intravenously every day. She then began to show signs of mental clearing. Within a week she had become alert and completely oriented. Two weeks later she began to vomit and again lapsed into coma. The following day she had two convulsions. This time she remained in coma for nine days. The deep tendon reflexes were absent. A uremic frost was noted. She appeared moribund. The blood urea nitrogen was 299 mg. per cent; creatinine 6.6 mg. per cent; phosphorus 4.5 mg. per cent; and calcium 4.5 mg. per cent. She again received large quantities of intravenous fluids and regained alertness and orientation. One and one-half months later she once again lapsed into coma after an episode of vomiting. It was noted that each time she became comatose the blood urea nitrogen would increase. On April 21, 1946 transfer to the Rhode Island Hospital was advised by the medical consultant. The discharge diagnosis at the State Hospital for Mental Diseases was: (1) ? hysteria; (2) episodes of alkalosis and azotemia of unknown etiology.

THIRD ADMISSION — 4/24/46-6/26/46. The patient was readmitted to the Rhode Island Hospital on April 24, 1946. Physical examination showed a poorly-nourished, mute, uncooperative patient. The abdomen was distended and tympanitic. There were bed sores on the buttocks and one plus edema of the extremities. The reflexes were equal and hyperactive. The patient weighed 80 lbs.

The urine on admission showed protein 3 plus; sugar 1 plus; no acetone; sediment 10-15 white blood cells, 1-2 red blood cells, a few granular casts; and a specific gravity of 1.010. The blood urea nitrogen was 146 mg. per cent; creatinine 11.2 mg. per cent; carbon dioxide combining power 137 volumes per cent; and sodium chloride 260 mg. per cent. Phenosulfonphthalein test on May 6 showed less than 5% excretion in two hours. Red blood

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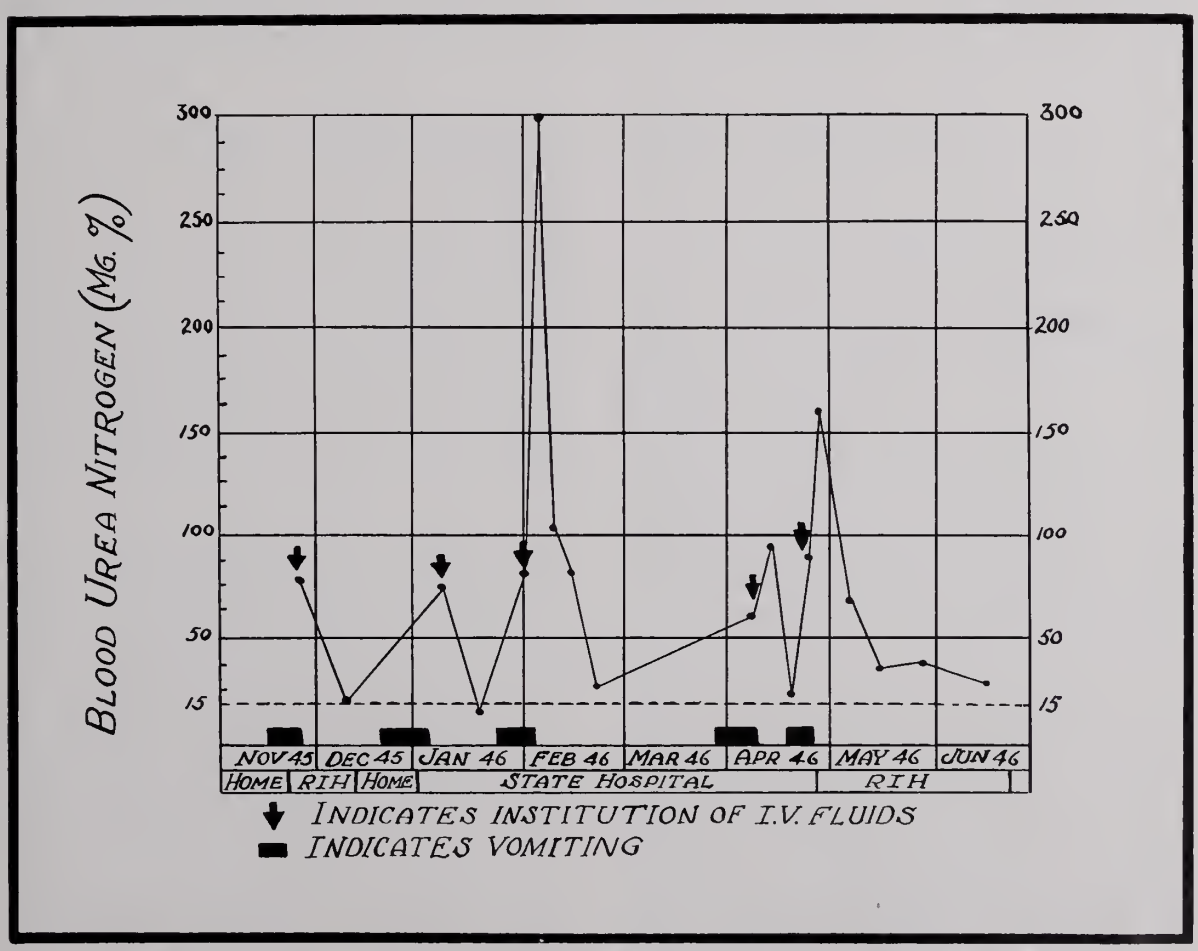


Figure 1. The relation of the blood urea nitrogen to episodes of vomiting and the response to the administration of intravenous saline.

count was 2,600,000; the white blood count was 10,500 with a normal differential.

It was felt that this patient's azotemia resulted from her vomiting and dehydration. She received large quantities of intravenous saline to correct her electrolyte imbalance. As soon as she was able to take fluids orally, she was given dilute hydrochloric acid and ammonium chloride by mouth. Later she was placed on a soft diet. However, aspiration of the gastric contents every night revealed a daily residue of at least 1000 c.c. Gastric analysis showed free hydrochloric acid. On May 27, 1946 blood urea nitrogen was 40 mg. per cent; creatinine 3.0 mg. per cent; and sodium chloride 495 mg. per cent. Study of this patient's family background revealed a long history of maternal domination. It was felt, however, that she had an organic lesion and as soon as she could retain a barium meal a gastrointestinal series was performed. This disclosed a tremendously dilated stomach. The duodenum did not fill with barium. The impression was pyloric obstruction probably due to ulcer. The patient received five transfusions of whole blood and on her 51st day in the hospital a subtotal gastrectomy was performed. At operation, the duodenum was found to be greatly narrowed and fibrosed in its proximal portion. A scarred ulcer was noted in the region of the pyloris. In the pathological report, edema and stenosis of the pylorus were described. Microscopic diagnosis was chronic gastritis and duodenitis. The postoperative course was uneventful and there was no further vomiting. The patient was discharged on June 26, 1946.

FOLLOW-UP NOTE—The patient was seen in the Outpatient Department on August 9, 1946 and reported a 30 lb. weight gain in the two months following discharge. The blood urea nitrogen at this time was 35 mg. per cent; creatinine 2.5 mg. per cent and sodium chloride 522 mg. per cent. The patient was seen again on December 26, 1946 and reported continued improvement. She was now working full time at her former job. Blood studies at this time showed a blood urea nitrogen of 30 mg. per cent; creatinine 2.0 mg. per cent; protein 6.5 gm. per cent; and sodium chloride 510 mg. per cent. The phenolsulfonphthalein test showed 35% excretion in two hours. The Fishberg urine concentration test showed a maximum specific gravity of 1.016. The urea clearance was 40% of normal standard clearance. On December 20, 1947, the patient was seen again and appeared robust. She now weighed 150 lbs. She reported no recurrence of nausea or vomiting in the one and one-half years since her operation. At this examination the blood urea nitrogen was 19 mg. per cent; creatinine 1.9 mg. per cent; and the phenolsulfonphthalein test 45% excretion in two hours. The urine concentration test showed a maximum specific gravity of 1.018 and the urea clearance was 59% of normal.

	PSP Test	*Urine Conc. Test Maximum S.G.*	*Urea Clearance*
11-15-45	65%	.....	.....
4-17-46	22%	1.028	.....
5-16-46	5%	1.008	.....
12-26-46	35%	1.016	40%
12-20-47	45%	1.018	59%

Table 1. Kidney function tests during various stages of the disease.

DISCUSSION — This case presents several features that warrant comment: 1. The episodes of convulsions, coma, and uremia always followed prolonged vomiting and were terminated by the administration of adequate fluid and electrolyte. The mechanism by which the vomiting led to the clinical picture of uremia, appears to have been as follows: The loss of water and hydrochloric acid by vomiting produced severe dehydration, hypochloremia, and alkalosis. The dehydration resulted in decreased blood flow through the kidneys and, consequently, impairment of renal function. The hypochloremia and alkalosis further contributed to the development of renal insufficiency and uremia. When the normal renal blood flow and normal electrolyte balance of the blood were restored by the intravenous administration of saline solution, the kidney function improved and the blood urea nitrogen dropped. At the same time, there was a corresponding clinical improvement. Since this patient gave no evidence of any primary disease of the kidney, this case fulfills the criteria of "prerenal azotemia".

2. The real nature of the patient's illness was not clarified until four years after her first admission to the hospital. During this period, she was moribund several times and it appears probable that she would have died if she had not received intravenous fluids in time. The diagnoses entertained at various times included brain tumor, gastric neurosis, schizophrenia, and hysteria. The real cause of the vomiting was finally established to be pyloric obstruction on the basis of a peptic ulcer. A curious feature is the fact that she never experienced pain. Once the obstruction was relieved by operation she made a rapid recovery and was able to return to a normal, productive life.

3. The blood chemistry values in this case were quite unusual. The carbon dioxide combining power of 137 volumes per cent was the highest ever reported by the laboratory of the Rhode Island Hospital. Other extremely abnormal values include the blood sodium chloride of 220 mg. per cent; the calcium of 4.5 mg. per cent and the phosphorus of 4.5 mg. per cent; the blood urea nitrogen of 299 mg. per cent; and the creatinine of 13 mg. per cent.

continued on page 377

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NAVY POLLUTION IN NARRAGANSETT BAY

FOR A YEAR or so we have had nothing to say about Water Pollution. Just previous to this the medical profession of the state had a good deal to do with stirring up interest in this matter which had been lying dormant during the war. The problem was forced into politics with the result that the Blackstone Valley Sewer Commission project is well under way and a bond issue has just been approved for the sewage disposal plant at Fields Point.

The Pollution Abatement Committee of Rhode Island has been formed and is decidedly active. It consists of members from many organizations, including two members of the Rhode Island Medical Society's Committee. Most of the cities and towns bordering on the water have been stirred into activity. Already $10,000,000 has been voted to improve old plants or construct new ones.

The State committee also reports that the oil situation has greatly improved and the oil companies are cooperating. This last is particularly pleasing to report for all the rosy prospects we have been painting are futuristic. We use this word in the theological sense of fulfillment in the future and not in the art sense which seems to many of us to bear no resemblance to reality.

Last year we were bearing down hard on Pawtucket. Now we are told that Providence is running much infected sewage into the Bay and is even carrying great amounts down the Bay and dumping them where otherwise the water did have some chance of being clean.

A few years ago there was considerable excitement about the state over the report that the Navy was going to move from Narragansett Bay. Well, we would have decidedly cleaner water if they did. The Navy has been a bad offender not only from its ships which of course are in an awkward predicament when lying in port but also from its shore installations which of course can easily install disposal plants.

The Navy has certainly thrown money around freely for its programs. But when decency demands that they take care of their human sewage they become as parsimonious as any New England deacon or Quaker elder. Admiral Cooley has been quoted in the paper as saying the Navy would install proper disposal plants when nearby towns did and he has been commended editorially by our local paper for his graciousness. We see nothing to commend when the richest organization in the world violates decency on the plea that some little

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poverty stricken town hasn't done all it should. We thought one of the proudest boasts of our armed services and one of the outstanding reasons for our success in the last war was their hygienic record. It is shocking to know of their sewer pipes discharging into our Bay.

The Pollution Committee has been in correspondence with our senior senator and he has communicated with the Navy. The replies he has received, after the supernatant pleasant words have drained off leave this residue: "The Naval Base has recognized the fact that the matter of pollution of Narragansett Bay from Naval shore establishments in the Newport area as well as from the nearby communities is a serious problem." and this regarding what they are doing about it—: "I am afraid that I cannot place the Navy Department on record as desiring that you undertake to have the necessary sum added to the 1948 appropriations for public works construction.

(signed) JOHN NICHOLAS BROWN
Acting Secretary of the Navy."

It must be unpleasant for our fellow citizen, with a home in Newport and a love for yachting to tell us that we must continue to wallow in the Navy's filth.

WHAT'S WRONG WITH THE PROFIT MOTIVE?

AT THE CLEVELAND session of the American Medical Association last January the Council on Medical Service reported that the insurance industry of this country has insured an estimated 44 million persons under health and accident coverage. The Council informs us further that it has established for itself a policy to require a one year period of operation of plans underwritten by private insurance carriers before such plans can have the seal of acceptance of the AMA. Yet a non-profit plan does not have to meet such a requirement. Thus a new organization with no experience is considered more acceptable than the Metropolitan Life Insurance Company which is participating in the Rhode Island Plan.

The insurance industry has a profit motive! This criticism, the major one leveled at the type of plan sponsored by our Society in its effort to lessen the cost of medical care for the individual, prompts us to pose the question of "What's wrong with the profit motive?" Is there any stronger motive by which this country can continue to provide the highest standard of living anywhere in the world today? Does anyone really believe that the standards we have built by competitive methods can be continued and improved by non-profit organizations?

The non-profit hospitalization plans have been a tremendous benefit, but their greatest boon has not been, to our way of thinking, the mere payment of hospital expenses, but rather the education of the public generally to the necessity for budgeting for a health need. The hospital bed now competes on an even basis with the radio, the mechanical ice box, and other necessities or luxuries for a share of the worker's pay.

Too much emphasis has been placed on the non-profit feature of the hospitalization and medical care plans, and the public has been left with the impression that the insurance industry is concerned only with the profits it may realize from its business. Yet of the seven largest companies active in group health insurance, five are mutual companies which cannot, under the law, make a profit!

One very successful nonprofit hospitalization plan (Blue Cross) shows that over a five year period it paid out of the subscriber's dollar $.69 in benefits, approximately $.09 in expenses, and carried the $.22 balance to surplus. Bearing in mind that no dividends to subscribers were paid, and that by reason of the contracts with institutions whereby service is guaranteed (thus freeing the plan of the imposition of public taxes as imposed on other insurance groups) it is easy to see that no major insurance company could duplicate the profitability of this operation. But had this non-profit plan charged adequate but not redundant rates it would have had a loss and expense ratio not far out of line with commercial companies.

As non-profit community institutions hospitals have from the beginning of the Blue Cross program insisted on non-profit sponsorship of hospitalization plans. That insistence, incorporated in the essentials set forth by the American Hospital Association in 1933, served to close the door to the insurance industry to participate equally in extending the scope of hospital insurance. The public was thus sold the idea that the only way for low cost insurance was by a non-profit community organization.

The medical care plans have followed a similar pattern. As a result, a program such as evolved by the Rhode Island Medical Society is excluded from the American Medical Care Plans organization because it is not exclusively non-profit. Likewise,

as noted above, the Council on Medical Service has been persuaded to throw up a barrier against the insurance industry that borders on the ridiculous.

Today, in the face of rising hospitals costs, the non-profit plans are finding themselves in the same yard as other insurance groups. Large surplus funds have been dipped into heavily, and the non-profit programs, without the sound actuarial experience of other insurance groups, have raised their premiums—as much as 35% here in Rhode Island where the enrollment is the highest in the country and where a tremendous reserve fund already existed.

We here in Rhode Island have no axe to grind for the insurance industry. We have set out to find a way to extend surgical care on a prepaid voluntary basis to as many persons as possible, and at the lowest practicable cost. We want everyone who has a good insurance policy to sell—one that meets the requirements set forth by the Society—to enter the competition here. But we want that competition on a fair basis, and always to the advantage of the people who will purchase the insurance.

Let's look at the latest classic in misrepresentation of the profit versus the non-profit program.

In March, 1947, the American Medical Association completed arrangements for a program providing hospital, surgical and in-hospital medical care benefits for employees of the Association. Hospitalization was with the Blue Cross of Chicago, and the surgical and in-hospital medical care program was underwritten by the Metropolitan Casualty Insurance Company of New York, as there was not in existence any medical society-sponsored surgical plan operating in Chicago or Illinois.

What happened?

During the year the Blue Cross raised the premium cost to the extent of some $1,600. And when time came for the renewal of the contract this past March no assurance was given by Blue Cross that it wouldn't raise its rates during the ensuing 12-month period. (Insurance companies cannot raise their rates during a benefit year as the Blue Cross does). The general manager of the AMA, Dr. George Lull, sought contracts from insurance companies, and reportedly submitted them to the Board of Trustees. Subsequently a contract was purchased from the Continental Casualty Company in Chicago to cover both the hospitalization and the surgical-medical care.

What happened then?

"The AMA is adding support to the proponents of a national compulsory system." "The AMA is repudiating the principle of non-government, non-profit, voluntary medically supervised hospitalization." "The AMA has 'sold out' to insurance interests. Etc., Etc." Such was the gist of the flood of medical society editorials, communications and resolutions from misinformed physician-editors, non-profit plans and medical associations. Resolutions are reported to be in preparation for the AMA House of Delegates this month asking that the action of the AMA in insuring its employees with a profit making plan be rescinded.

What is the true story?

The Chicago prepaid non-profit surgical plan was not selling policies at the time of the AMA contract renewal, and therefore no local non-profit plan was available. Also, the Illinois Medical Society is developing a plan similar to that in Rhode Island utilizing the insurance industry.

Therefore the issue centered around the program offered by the non-profit hospitalization organization which nationwide claims it wants competition from the insurance industry.

But, by purchasing the contract from the PROFIT making company the AMA will pay a reported $2,277 LESS annually than it would have to pay the non-profit plan for contracts not offering as substantial benefits!

What's wrong with the profit motive, then? It is an honorable motive. Abuses in the form of excessive profits can be prevented. In effecting such preventive measures there is no need to destroy the system by the substitution of monopolies or non-profit programs, any more than there is need to regiment the entire medical profession to improve the medical care in certain areas of the country, or among certain groups of people in all sections.

PROFOUND PRERENAL AZOTEMIA RESULTING FROM PYLORIC STENOSIS

concluded from page 374

4. Another noteworthy feature was the residual renal insufficiency. One and one-half years following operation, the patient still showed abnormal values for the urine concentration test, the phenolsulfonphthalein test, and the urea clearance. It may be speculated that irreversible changes have occurred in glomeruli and tubules as a result of the profound chemical derangement of the blood.

SUMMARY—(1) A case of profound prerenal azotemia, resulting from vomiting, in a 45-year-old female is presented.

(2) Following a subtotal gastrectomy for stenosing duodenal ulcer the patient made a remarkable clinical recovery.

(3) One and one-half years following operation there were still signs of residual renal impairment.

REPORT OF THE HEALTH INSURANCE COMMITTEE

TO THE HOUSE OF DELEGATES OF THE RHODE ISLAND MEDICAL SOCIETY

MAY 5, 1948

THE DEVELOPMENT of the Rhode Island Plan, the prepaid voluntary non-occupational surgical-obstetrical insurance program of the Rhode Island Medical Society, has necessarily developed slowly in the past four months.

Several important factors are called to your attention.

The Society had as its major motive the development of a program that would materially aid the person in the low-income group. All its planning was in that direction, with the understanding that aid to persons in such a category was of major concern. Hence a service provision was accepted by the Society to provide complete benefits to persons within specified income levels.

Much public discussion has centered on the service feature of the program. That is natural in view of the complete indemnity offered by it. But no one should lose sight of the fact that the program offers a definite contribution for every insured person, for the indemnity benefits compare most favorably with the best insurance plans in the country, and these same benefits are not available at similar cost in any other insurance contract. For every person, regardless of his income, the plan offers many attractive features.

This voluntary action of the medical profession is duplicated by no other professional or non-professional group of individuals.

Yet our Plan has been subject to disapproval by the officers of an organized labor group, and it has not been supported fairly by the daily press, because it does not embrace a larger section of the population who earn incomes that definitely remove them for what is generally understood across the nation as 'low income'. We are not unduly concerned by such reactions. We see in them a misunderstanding, a failure to appreciate our motives.

We have been challenged because our progress has been slow. But little recognition has been given to the fact that we are pioneering in a plan that may well set a pattern across the nation. Other state medical societies are now proposing plans very similar to ours, and all are looking towards our development for experience and technical advice. Among the state medical societies in this group are Maine, Wisconsin, Illinois, and Tennessee.

Thus it is apparent that what we do here will have a profound effect upon the planning for social security nationally. Our critics will do well to look to the state cash sickness compensation program which has been subject to criticism through the years because it was not adequately planned, and to a non-profit hospitalization plan in a neighboring state that sustained severe setbacks because of the introduction of contracts that were not practical in operation.

Actually a tremendous amount of work has been carried forward by your committee. Several conferences have been held with insurance representatives, and many technical issues relative to the policies submitted have been clarified. For example, final approval of several policies was held up pending a clear understanding by the insurance company of the Society's intention to cover injuries not compensable under the workmen's compensation law.

We have studied various claim forms, seeking to find a suitable one to be standard for all policies under the plan. We have prepared a direction to pay and physicians agreement form that we hope will simplify that important phase of the program; and we have given careful consideration to action to be followed relative to unlisted procedures, and to complaints that may arise in the handling of claims. The roster of participating physicians has been compiled, numbering at present 553, and a listing by cities and towns has been prepared for use by insurance companies and the public generally.

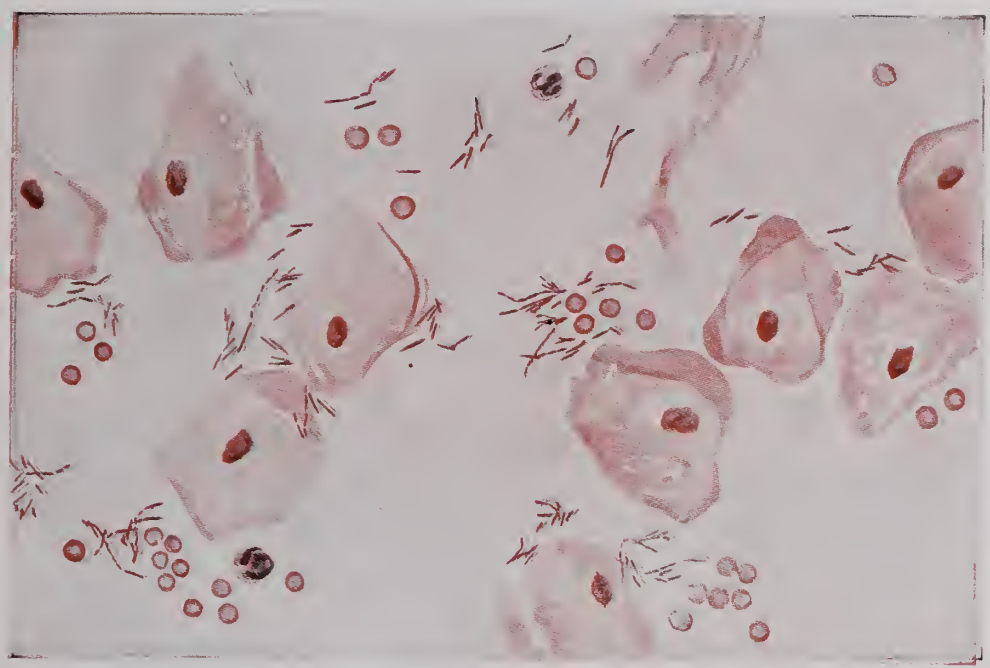
We have the assurance from the Truesdale Hospital staff of Fall River, Massachusetts, that it will accept the provisions of our plan when rendering treatment of any insured under it who may be hospitalized there. We have considered the possibility of making the suggestion to the staffs of hospitals in other communities bordering on Rhode Island that they consider the adoption of the same attitude as the Fall River group.

We have completed a question and answer summary that will be published in the RHODE ISLAND MEDICAL JOURNAL, and which we hope to make available in brochure form for statewide public distribution.

continued on page 380

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REPORT OF HEALTH INSURANCE COMMITTEE

continued from page 378

We have been encouraged by the response of the insurance companies. As they have become familiar with the details of the proposed plan they have now submitted policies, and at present we have received policies from thirteen companies, most of which have been approved. The companies are:

Aetna Life Insurance of Hartford
American Mutual Liability of Boston
Connecticut General Life of Hartford
Continental Casualty of Chicago
Employers Mutual Liability of Wisconsin
Equitable Assurance of New York
John Hancock Mutual Life of Boston
Liberty Mutual of Boston
Massachusetts Mutual Life of Springfield
Metropolitan Life of New York
Monarch Life of Springfield
Travelers of Hartford
Washington National of Chicago

Other companies have expressed an interest in the plan, and have given assurance that they will participate as soon as it is possible for them to do so. Yesterday members of our Committee met with representatives of the Prudential Life Insurance Company of Newark, and we anticipate the participation of that company in the near future.

These represent the bulk of the major insurance companies writing in the health and accident field. Once they have organized their sales forces, have developed their promotional programs, and have stimulated public interest in the advantages of the Rhode Island plan we feel certain that there will be support from industry, labor, and the public in general.

Policies for sale will at first be restricted to groups. But we are informed that three, at least, of the companies will accept enrollment as low as groups of five. This presents a coverage for the small industrial establishments, office groups, etc., and we believe that no medical society sponsored plan in the country has as yet started on such a favorable basis.

When the Society announced its plan it provided that it should be under no obligation whatsoever to review the premium rate or rates of those policies submitted for its approval, since it is the desire of the Society to permit such rates to seek their natural levels through competition.

However, your Committee has naturally been interested in the premium rates to be charged for policies under the plan. We have viewed the rates submitted by some of the companies and we are encouraged that by competition there will be a variance that augurs well for the sale of policies. Cognizant of the sizeable female employment in Rhode Island, some companies have found it advisable to have their minimum monthly rate increased for exposure on eligible female employees; other companies have decided on a flat rate regardless of the female worker population.

For example, the average minimum monthly premium rate of several policies viewed is 54c for the employee, and it is scaled upward for female coverage, since obstetrical benefits are provided, so that the rate would be 85c where 55% of the employees are females. For dependents the monthly flat rate, including obstetrical benefits for wives, is about $1.75, and for families from $2.50, ranging up or down according to whether obstetrical coverage is elected as immediate or waived for a nine month waiting period.

This range in premiums, scaled according to benefits desired, will result in some of the policies offering additional features of value to the insured. We interpret this as a healthy situation in a country where competition is allowed to exist and flourish to the advantage of the purchasing public.

In the public press there has appeared on one occasion a comparison of the rates of one company whose policy was approved by your Committee with the rates of some of the non-profit medical care plans in other parts of the country. Such a comparison on the actual premium charge alone without any consideration of the provisions of the different policies involved is most misleading and warrants criticism.

Consider these differences:

There is a variance in indemnity schedules in the different plans, and undoubtedly many do not benefit the insured to the extent that the Rhode Island Plan does.

Many non-profit plans do not include surgical services when rendered outside a hospital. The Rhode Island Plan does.

Many non-profit plans have lower income limits than those of the Rhode Island Plan, thus not providing as attractive a service feature. Some plans do not even include the service feature.

Most non-profit plans impose a waiting period for obstetrical coverage. There is provision for immediate coverage for enrolling groups under the Rhode Island Plan.

Waiting periods, besides for maternity, are imposed by most non-profit plans for certain surgical procedures, such as tonsil and adenoid operations, hernia, hemorrhoids, etc. Such waiting periods are not included under the Rhode Island Plan.

* * *

These examples indicate clearly the fallacy of comparing plans merely on the basis of the pre-

continued on page 386

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1. If you feel sick, call your doctor at once. Don't wait for a serious illness to develop before you ask his help. The sooner he sees you, the more he can do to help you avoid a major illness.

2. Before you telephone your doctor, make a list of the questions you want to ask him. Have a paper and a pencil handy when you call, so that you may take down his instructions. This way you will save your doctor's time, and remember *accurately* what he tells you.

3. Answer your doctor's questions *fully*. A previous illness may not seem to you to have any bearing on your present condition. But to your doctor it might furnish a valuable clue. Tell him complete facts. Let *him* decide what is important.

4. Follow your doctor's instructions *exactly*. If he prescribes medicine, take it *according to directions*. Remember, a larger dose than that prescribed won't cure you faster. And it might be harmful.

5. Never use medicine prescribed for somebody else, or for a previous illness of your own. However similar your symptoms may appear to you, the nature of your illness may be quite different. Only your doctor can accurately diagnose your trouble and prescribe proper treatment.

6. If your doctor advises an operation, don't put it off. With modern surgery, modern hospital care, you seldom have reason to fear an operation.

7. The new medical treatments you read about in the popular press aren't likely to be news to your doctor. If your doctor has not recommended a new treatment to you, it is probably because there are still some questions about its value, some limitations not stressed in popular reports, or some factors in your case which would make the treatment undesirable or ineffective for *you*.

8. Don't ask your doctor to advise you about members of your family whom he himself has not seen. He cannot risk giving an opinion about a patient of whose condition he has no firsthand knowledge.

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PROPOSED DRAFT OF PHYSICIANS

—As Reported by the Bureau of Legal Medicine of the American Medical Association—

THE SENATE and House bills (S. 2655, H.R. 6401) to reactivate selective service have now been favorably reported respectively by the Senate and House Committees on Armed Services. Each contains a special provision for the induction of physicians under forty-five years of age.

There follows the exact phraseology of each such provision and statements contained in the Senate and House Committee reports in justification of the provision.

S. 2655, introduced by Senator Gurney, a bill to provide for the common defense by increasing the strength of the armed forces of the United States, including the reserve components thereof, and for other purposes

"Sec. 4 (c) (1). Notwithstanding any other provision of this Act, the President is authorized, pursuant to requisitions submitted by the armed forces, to require special registration of and to make special calls for members of the medical and dental professions and allied specialist categories who have not attained the age of forty-five at the time of such call in such classifications as he shall determine. Persons in medical and dental categories shall be inducted in accordance with the following priorities:

First. Participants in the Army specialized training program or similar programs conducted by the Navy and persons who were deferred from training and service during World War II for the purpose of pursuing a course of instruction leading to education in one of the above professions, and who have had no active service as commissioned officers exclusive of time spent as intern.

Second. Those who did not have active service during World War II.

Third. Those who served the least numbers of full months during World War II.

Persons called hereunder shall be liable for induction into the armed forces for training and service for twenty-four consecutive months, in accordance with such procedures as the President shall prescribe.

(2) No doctor of medicine or dental surgery who, on the effective date of this Act, was established in his profession in the community in which he resides shall be called for induction under the provisions of this subsection, and no such doctor of medicine or dental surgery who is a member of a reserve component of the armed forces shall hereafter be ordered to active duty for more than one month in any calendar year (except for purposes of training), if the local board within the jurisdiction of which he resides has determined that the health of the community in which he resides will be unduly jeopardized as a result of his induction or service on active duty. The foregoing provisions of this paragraph shall not apply to any doctor of medicine or dental surgery who participated in the Army specialized training program or any similar program conducted by the Navy, or who was deferred from service in the armed forces during World War II for the purpose of pursuing his medical or dental education, if he has not served on active duty as a commissioned officer for a period of more than ninety days exclusive of training duty or internship."

Excerpt from Senate Report No. 1268 on S. 2655

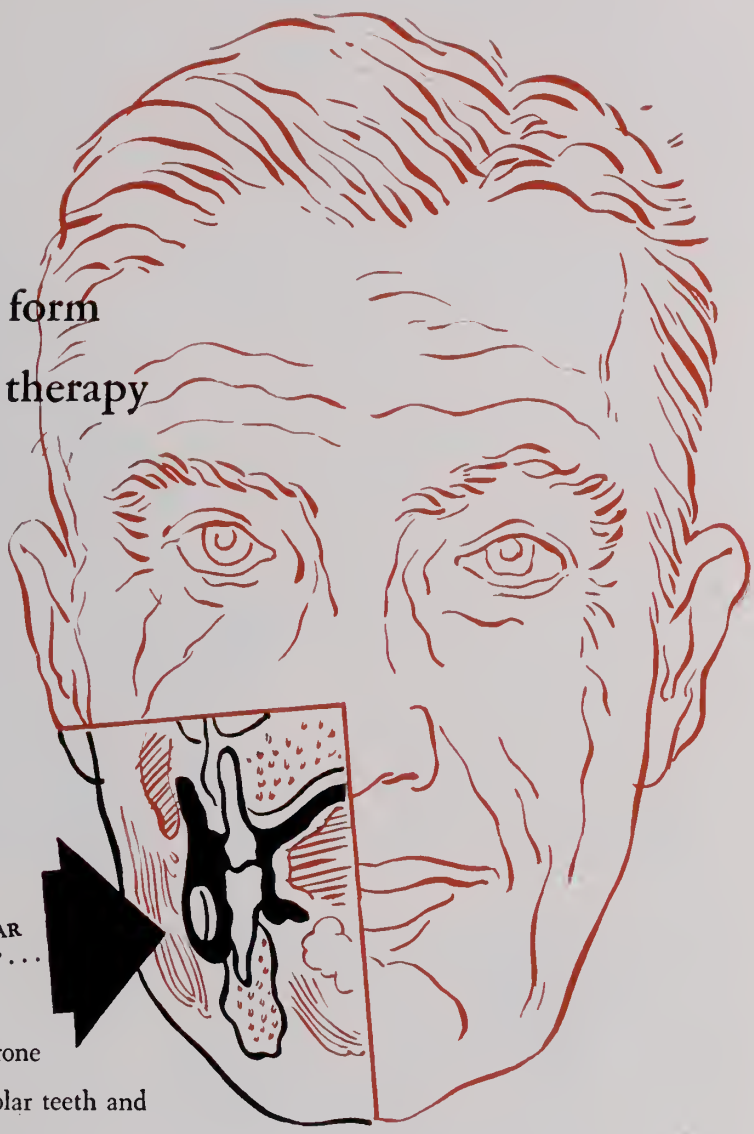
"Sec. 4 (c) *Special calls for certain specialist categories.* (1) To meet the health needs of the armed forces specific authority is given which permits a special registration of, and calls for, members of medical and dental professions who have not reached age 45 at the date of their induction. In view of the complex structure of the sciences allied to the broad fields of medicine, surgery, and dentistry, similar authority is intended with respect to allied specialist categories. Although full cognizance has been taken of the very serious effects which would eventuate if excessive numbers of personnel mentioned in this subsection were to be withdrawn from civilian communities for service in the armed forces, no restrictive numerical limitations have been placed upon the executive department in this particular connection. The responsibility for safeguarding the health of the armed forces is primarily an executive matter, as is the proper utilization of manpower and material resources in meeting civilian needs. The committee feels that the details of allocating, between the

continued on page 384

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1. Lisser, H.: Calif. & West. Med., 64: 177, 1946.

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PROPOSED DRAFT OF PHYSICIANS

continued from page 382

armed forces and the civilian population, the personnel referred to in this subsection, comes within the recommendations expected of the National Security Resources Board and its Medical Advisory Committee, and that the fixing by statute of definite numbers of practitioners to be taken into the armed forces could conceivably result in a serious imbalance within either the armed forces or the civilian population in the event of emergencies not foreseeable at the present moment.

(2) However, as an extra safeguard for communities having few doctors in relation to their medical needs, this paragraph further provides that no doctor or dentist shall be called from a community in which the local board shall determine that his induction or call to active duty will unduly jeopardize the health of such community. This limitation would not apply to doctors who received their education under the Army specialized training program or similar programs, or who were deferred from service in World War II to complete their education."

H. R. 6401, introduced by Congressman Andrews, N. Y., a bill to provide for the common defense by increasing the strength of the armed forces of the United States and for other purposes

"Sec. 4 (c) (1). Notwithstanding any other provision of this Act, except sections 20 (b) and 23, the President is authorized, pursuant to requisitions submitted by the armed forces, to require special registration of and to make special calls for members of the medical, dental, osteopathic, veterinary, pharmacy, and optometric professions, who have not yet reached the age of forty-five at the time of such call, in such professional categories as he shall determine, and persons called hereunder shall be liable for induction for not to exceed twenty-four months of service in the armed forces: *Provided,* That during the life of this Act there shall be, in the Army, including the Air Force, and in the Navy, including the Marine Corps, a ratio to total active strength of not to exceed five doctors of medicine and two dentists per one thousand men, one osteopath per five thousand men, one veterinarian per two thousand men, and one pharmacist and one optometrist per three thousand men.

(2) In inducting persons pursuant to paragraph (1) of this subsection, the President shall induct, in the following order of priority:

First. Those who participated as medical or dental students in the Army specialized training program or similar programs administered by the Navy, and persons who were deferred from service during World War II for the purpose of pursuing a course of instruction leading to education in one of the above professions, and have had no active duty as commissioned officers.

Second. Those who participated in the Army specialized training program or similar programs administered by the Navy and who have served on active duty as commissioned officers for less than twenty-four months (exclusive of time spent as intern).

Third. Those who are less than thirty-five years of age and have had less than ninety days' prior active honorable military or naval duty.

Fourth. Those who are over thirty-five years of age and have had less than ninety days' prior active honorable military or naval duty.

Fifth. Those whose total active honorable military or naval duty is less than twenty-four months.

Sixth. Others as prescribed by the President."

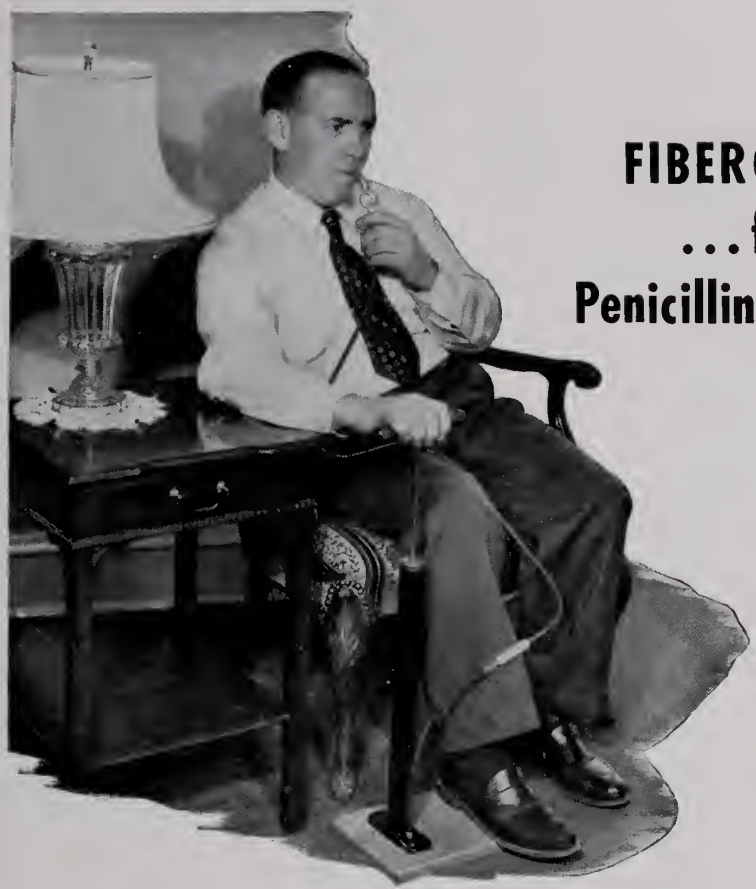
Excerpt from House Report No. 1881 on H. R. 6401

"Subsection (c) of this section (Section 4) renders doctors, dentists, osteopaths, veterinarians, pharmacists, and optometrists especially liable to service up to the age of 45 for a 2-year period of service. The committee imposed numerical limits on the numbers of such professional persons who could be inducted. The subsection requires that these persons can be inducted in only such numbers as necessary to maintain the following ratios to active-duty strength: Doctors, 5 per 1,000; dentists, 2 per 1,000; osteopaths, 1 per 5,000; veterinarians, 1 per 2,000; pharmacists and optometrists, 1 per 3,000. The committee also specified that these persons could be inducted only pursuant to specified priorities which are determined to be as follows: The first group are those without any active commissioned service who were educated at Govern-

continued on page 386

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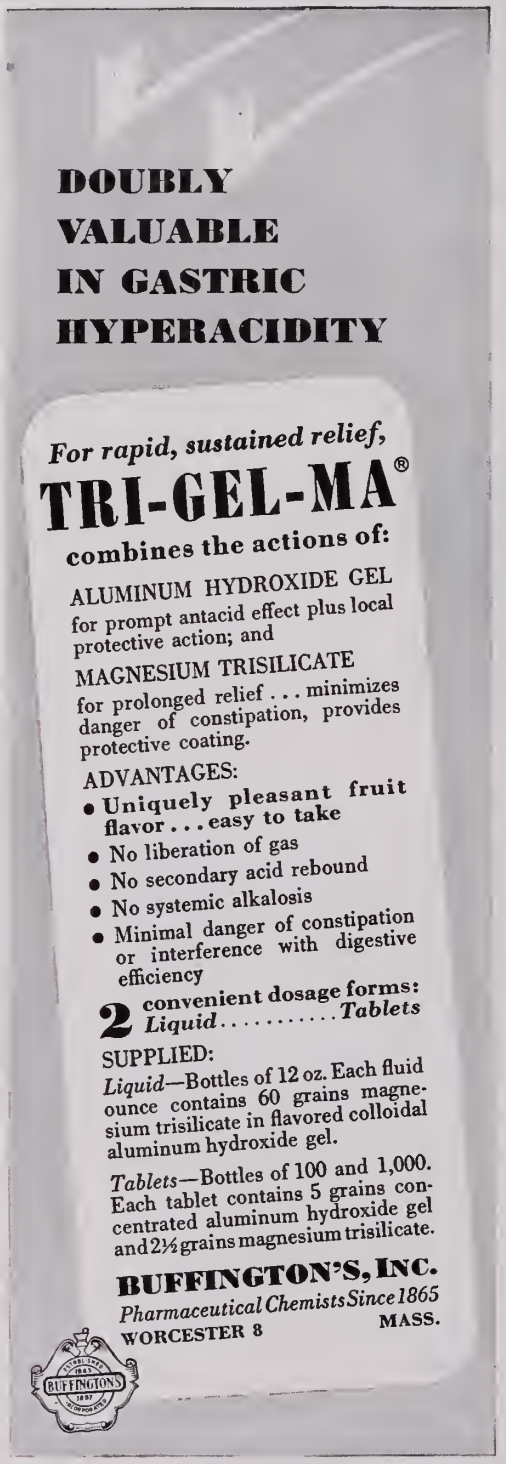
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†Finke, Walter, M.D., Simplification of penicillin aerosol therapy for home treatment, American Practitioner 1: 643-644, Aug. 1947.

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PROPOSED DRAFT OF PHYSICIANS

concluded from page 384

ment expense during the war and those without any active commissioned service who were deferred from military or naval service during the war to complete their education. The second group is those who were educated at Government expense and have had less than 2 years of active commissioned service in the armed forces. The third group is those under 35 who have had less than 90 days' service. Next are those over 35 with less than 90 days' service. Next, those with less than 2 years' service; and lastly, others as specified by the President."

REPORT OF HEALTH INSURANCE COMMITTEE

concluded from page 380

mium charge. They also indicate the more liberal provision of insurance contracts written for sale under the program of the Rhode Island Medical Society.

Our program is open to the non-profit Blue Cross organization of Rhode Island. The Society has accorded it the same opportunity to join with other insurance companies, profit and non-profit, in providing a contract including at least the basic provisions set forth by the Society. We sincerely hope that the Blue Cross of Rhode Island may eventually see its way clear to participate without being accorded any special underwriting privileges not common to all companies operating under the plan.

The plan we have evolved within our Society will have to be evaluated over a period of years to determine its true success. Our program is under the supervision of the public directly through the state insurance commissioner. It has the backing of the major insurance companies of America, including the great Metropolitan Life Insurance Company, long a leader in the promotion of outstanding health programs. Its service feature is guaranteed by the medical profession of Rhode Island, and its indemnity benefits are most liberal.

We have confidence in the insurance industry of this country to make this plan a successful contribution to the social security of the people of Rhode Island.

Committee on Health Insurance

ROCCO ABBATE, M.D., *Chairman*
CHARLES J. ASHWORTH, M.D.
J. MURRAY BEARDSLEY, M.D.
ARCADIE GIURA, M.D.
CHARLES L. FARRELL, M.D.
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HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY

Report of Meeting Held on May 5, 1948

A REGULAR MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, May 5, 1948. The meeting was called to order at 8:30 p.m. by the President, Arthur H. Ruggles. The following were in attendance:

Rocco Abbate, M.D.
Robert Baldridge, M.D.
J. Murray Beardsley, M.D.
Alex M. Burgess, M.D.
James Callahan, M.D.
Peter Pineo Chase, M.D.
Paul C. Cook, M.D.
G. Edward Crane, M.D.
Morgan Cutts, M.D.
William P. Davis, M.D.
Donald DeNyse, M.D.
Augustine W. Eddy, M.D.
Charles L. Farrell, M.D.
David Freedman, M.D.
Isaac Gerber, M.D.
Henry Hanley, M.D.
Peter F. Harrington, M.D.
Robert Henry, M.D.
William A. Horan, M.D.
Russell R. Hunt, M.D.
Albert H. Jackvony, M.D.
Louis I. Kramer, M.D.
Herman A. Lawson, M.D.
Earl J. Mara, M.D.
Edward A. McLaughlin, M.D.
John C. Myrick, M.D.
Joseph C. O'Connell, M.D.
Edwin B. O'Reilly, M.D.
Arthur H. Ruggles, M.D.
Daniel V. Troppoli, M.D.
George W. Waterman, M.D.
Guy W. Wells, M.D.

Also in attendance were Drs. Earl F. Kelly and James P. Healy of Pawtucket, Dr. Francis B. Carroll, New England Regional Director of the Veterans Administration, Mr. Charles W. Williamson, Legal Counsel and Mr. John E. Farrell, Executive Secretary.

SECRETARY'S REPORT

The Secretary submitted his report, a copy of which had been furnished to each delegate, in which actions of the Council relating to National Emergency Medical Service, membership of the Society in the Council of the New England State Medical Societies and the Conference of Presidents and other officers of State Medical Associations, the purchase and distribution of copies of the American Medical Association's principles of medical ethics for the membership of the Society, the memorial tablet to fellows who died while in military service during World War II, and the developments relative to the Fiske Fund, were listed.

It was moved that the report be accepted and placed on file.

RECOMMENDATIONS FROM THE COUNCIL

The Secretary submitted recommendations from the Council.

Nominations for officers and Standing Committees for 1948-49

A motion was made and seconded that the list of nominations for officers and standing committees of the Society to serve for a twelve month period from May, 1948, to May, 1949, be accepted. There were no counter nominations from the floor and therefore the motion was unanimously adopted. (The complete list of the elected committees will be published in the May issue of the RHODE ISLAND MEDICAL JOURNAL.)

The Annual Meeting in 1949

The Council recommends to the House of Delegates that the annual meeting of the Society in 1949 be held on Wednesday, May 11, and Thursday, May 12, and that the Committee on Scientific Work and the Annual Meeting give consideration to the invitation of the Councillor from Newport that the meeting be held in that city. It was moved and seconded that the recommendation be adopted. The motion was carried.

Appointments to the Curative Center

The Council recommends that the advice and consent of the House of Delegates be given to the proposal of the Acting Director of the State Department of Labor that he re-appoint Dr. Edward A. McLaughlin and Dr. Albert H. Jackvony as members of the Advisory Board to the Curative Centre. The motion was made and seconded that

continued on page 390

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HOUSE OF DELEGATES
continued from page 388

the recommendation be adopted. The motion was adopted.

VETERANS HOSPITAL IN PROVIDENCE

The Secretary reported communications from the Veterans Administration in Washington and from the regional office in Boston in answer to the proposal of the House of Delegates of the Rhode Island Medical Society to have a committee to assist in the problems of staff organization of the Veterans Hospital in Providence.

Dr. Arthur H. Ruggles stated that he had invited Dr. Francis B. Carroll, New England Regional Director of the Veterans Administration, to address the House and to explain the position of the Veterans Administration in the matter at hand.

At the request of the Pawtucket delegation, the Secretary read a resolution adopted at a meeting of the Pawtucket Medical Association on April 29, 1948, which read as follows:

"WHEREAS, we have learned through the press and radio that Dr. Francis B. Carroll, Veterans' Administration Director for New England, has named a Dean's Committee to correlate the medical services of the Veterans' Hospital and teaching program of Brown University,

WHEREAS, such committee has been appointed by Dr. Henry M. Wriston of Brown University,

WHEREAS, said appointed committee is contrary to and in disagreement with a prior committee duly elected by the House of Delegates of the Rhode Island Medical Society, after the various hospitals in the state had submitted nomination,

BE IT RESOLVED, that the members of the Pawtucket Medical Association, duly assembled,

(1) Re-affirm our faith in the democratic process of government both within and without our organization.

(2) Re-affirm our faith in the ability of the Committee duly elected by our policy making body, the House of Delegates, of the Rhode Island Medical Society,

(3) Feel strongly that members who have accepted positions on Dr. Wriston's committee, having prior knowledge of the wishes of the Rhode Island Medical Society, have acted most unwisely,

(4) Urge the House of Delegates to re-affirm its stand and support the duly elected committee of the Rhode Island Medical Society,

(5) Instruct delegates of the Pawtucket Medical Association to vigorously oppose any change in the Rhode Island Medical Society Committee as now constituted,

BE IT FURTHER RESOLVED, that copies of this resolution be sent to the Secretaries of the Rhode Island Medical Society, and all district medical societies, all hospital staffs of the state and Dr. Carroll."

There was lengthy discussion with many members of the House of Delegates participating.

A very brief summary (complete notes are on file at the Society's executive office) of the highlights of the discussion is as follows:

Dr. Carroll reviewed the Veterans Administration program for hospitalization of veterans, and outlined the purpose of a Dean's Committee, citing as one of its major roles that of assisting in a teaching program, and naming consulting and attending physicians to the hospital. To date no consultants or attending physicians have been named for the Providence Veterans Administration Hospital, but the local Dean's Committee will make recommendation to him for appointments. The Dean's Committee serves without compensation.

In March, 1946, Dr. Winthrop Adams, then regional Veterans Administration medical director, expressed the hope that Brown University might be of help in forming the Dean's Committee for Rhode Island. Subsequently, Dr. Wriston, president of Brown, was approached on the matter and he designated the department of medical sciences of the University to assist in the task.

Dr. Carroll reported that he did not know of the plans of the Rhode Island Medical Society as made known to Dr. Paul R. Hawley, and as enacted by the House of Delegates. He also stated that it has not been the policy of the Veterans Administration to consult any state medical societies in the matter of Dean's Committee, but he will now

continued on page 392

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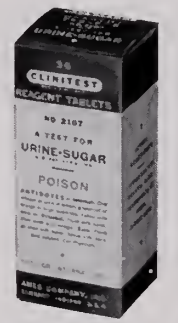
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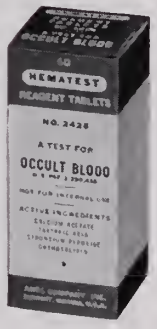
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HOUSE OF DELEGATES

continued from page 390

call to the attention of the Central Office the importance of such a step.

In explanation of his acceptance of service with the Dean's Committee, Dr. Alex M. Burgess stated that he first heard of the contemplated plan for such a committee in Rhode Island on October 17, 1947. He had a letter from Dr. Carroll stating that a Dean's Committee probably would be formed in connection with Brown University. At the time of the House of Delegates meeting in November he suggested in the report of the Committee on Postgraduate Education that the committee cooperate with the Veterans Administration if they sought assistance. It was his understanding that a Dean's Committee could not be established through a medical society but would have to be established through a university. He was later asked by Dr. Carroll to come to Boston and to serve as a consultant to the Veterans Administration regional office, but this work has nothing to do with the Dean's Committee. On February 24, 1948, Dr. Cushing wrote to Dr. Wriston and he recommended the department of medical sciences as the personnel for the committee. On March 5, 1948, the committee was appointed.

In answer as to how the committee could now be changed, Dr. Carroll reported that the Dean's Committee itself could change its membership. The question of a resolution to Dr. Magnuson and Dr. Carroll to express the wishes of the Society was discussed, and the discussion was concluded with the following motions, both of which were adopted:

1. Dr. Joseph C. O'Connell moved that the House of Delegates request the Veterans Administration, through Dr. Francis B. Carroll, regional medical director for New England, that he increase the membership of the Dean's Committee in Rhode Island by the addition of at least three members who will represent the other academic colleges in Rhode Island other than Brown University.

2. Dr. Earl Mara moved that the House of Delegates re-affirm its appointment of its statewide committee elected by the House of Delegates in January, 1948, and that it instruct that Committee to serve as advisors to the Dean's Committee of the Veterans Administration in Rhode Island, that it also keep the House of Delegates informed from time to time of the progress and development of the Veterans Administration hospital program in Rhode Island.

Annual Report (1947) of the Treasurer

In the absence of Dr. Charles J. Ashworth, Treasurer, his annual report for 1947 was presented by Dr. Morgan Cutts, Secretary. A mimeographed summary of the introduction to the report

continued on page 394

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HOUSE OF DELEGATES

continued from page 392

had previously been submitted to each delegate. By consent of the House the reading of the financial statement was omitted when Dr. Ruggles reported that it had been previously read to the Council and approved by that body.

Dr. Charles L. Farrell moved that the report of the treasurer be adopted. The motion was seconded and unanimously carried.

REPORTS OF COMMITTEES

Report of the Health Insurance Committee:

Dr. Rocco Abbate, chairman of the Health Insurance Committee, presented a progressive report listing the 13 major insurance companies as participants under the plan and explaining the work of the committee during the past several months. A complete copy of the report was submitted to each member of the House of Delegates. (The report will be published in the June issue of the R. I. Medical Journal.)

Child Health Service Study:

Dr. Ruggles called to the attention of the House that a progress report from the local committee of the American Academy of Pediatrics participating in the Child Health Services Study had been submitted by Dr. Buffum and a copy had been sent to each member of the House of Delegates. There was no action taken on this report.

Committee on Postgraduate Education:

Dr. Alex M. Burgess, chairman of the Committee on Postgraduate Education, reported that a list of meetings, clinics and similar educational exercises held at the various hospitals which members of the Rhode Island Medical Society are privileged to attend will be published in the May issue of the Rhode Island Medical Journal. The medical profession of the state is thus offered an excellent opportunity to keep in touch with modern medicine in its various branches.

He called attention to the list of specialists submitted to the House of Delegates as a result of the tabulation of a card survey to the members conducted by the Committee. He stated that this list will not be published and that it is by no means complete, and that any member noting any errors or omissions is requested to communicate with the Executive Office of the Society in order that the list may be corrected.

MISCELLANEOUS BUSINESS

The Secretary reported the receipt of a resolution from the Woonsocket District Medical Society relative to the eligibility of certain physicians in that area for licensure. It was moved that the resolution be referred to the Committee on Public Policy. The motion was seconded and adopted.

Resolution upholding action of the American Medical Association's Board of Trustees

Dr. Rocco Abbate presented the following resolution:

WHEREAS the General Manager and the Board of Trustees of the American Medical Association, acting in the best interests of the employees of the Association, have provided for them a plan of prepaid hospital and medical care insurance on a group basis, sharing with the employees the cost of such insurance, and

WHEREAS this action has been unjustly and unfairly criticized by many non-profit hospital and medical care organizations, and even by some medical societies, because the insuring company is not organized wholly for non-profit, and

WHEREAS, the insurance jointly purchased by the Association and its employees provides more benefits at a lower cost than obtainable through a non-profit plan, and

WHEREAS, competition in free enterprise is one of the bulwarks of American economic freedom,

THEREFORE BE IT RESOLVED, that the Rhode Island Medical Society express its approval of the sound action taken by the General Manager and the Board of Trustees of the American Medical Association in this matter, and express its disapproval of the unwarranted resolutions and actions directed against the aforesaid officers in this instance.

It was moved and seconded that the resolution be adopted.

Resolution relative to the American Medical Association Seal of Acceptance for the Rhode Island Surgical Plan:

Dr. Charles L. Farrell presented the following resolution:

WHEREAS the Rhode Island Medical Society has sponsored a prepaid, voluntary surgical-obstetrical insurance plan under which all insurance companies licensed in Rhode Island, including the Hospital Service Corporation (Blue Cross) of Rhode Island, may equally participate, and

WHEREAS all policies under the Rhode Island Plan are subject to the approval of the Rhode Island Medical Society and can be sold only with such approval, and

WHEREAS, as of this date, May 5, 1948, thirteen major insurance companies, profit and non-profit, including the Metropolitan Life Insurance Company, have submitted policies for approval by the Rhode Island Medical Society, and

continued on next page

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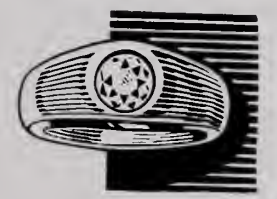
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WHEREAS some of these great insurance companies are already selling policies under the Plan, and at premium rates comparable to the so-called non-profit plans in other parts of the country, and in many instances with wider coverage, and

WHEREAS the Rhode Island Medical Society has been informed that the Council on Medical Service of the American Medical Association has established a policy to require a one year period of operation for plans underwritten by private insurance carriers before such plans are formally considered for receiving its seal of acceptance,

THEREFORE, BE IT RESOLVED, that the Rhode Island Medical Society request that the House of Delegates of the American Medical Association discourage such discriminatory regulations as regards plans sponsored and approved by state or county medical societies as being contrary to the purposes for which the Council on Medical Service was established, as being unfair to the insurance industry of this country which the Council on Medical Service itself, at the Cleveland Session this year, reported has insured an estimated 44 million persons under health and accident coverage, and as being a penalty to the state or county medical society that does not endorse the non-profit program exclusively.

The resolution was adopted.

Blue Cross-Blue Shield Merger:

Dr. Arthur H. Ruggles read communications from the Council on Medical Service of the American Medical Association urging each state to have representatives at a meeting at the American Medical Association headquarters on June 19, to discuss a proposed Blue Cross, Blue Shield merger on the national level. He also read communications from a physician in Oregon and from the New Mexico Physicians Service opposing such a merger. He stated that an effort would be made to have a member of the Society's Health Insurance Committee attend this meeting.

Resolution Regarding Cash Sickness Study:

Dr. Charles L. Farrell presented the following resolution:

WHEREAS the House of Delegates of the American Medical Association in meeting at San Francisco in July, 1946, adopted a resolution presented by the Rhode Island Medical Society which requested that the American Medical Association, through the proper Council or Bureau, make a complete study of the existing and proposed compulsory temporary disability compensation programs, such as the compulsory Rhode Island Cash Sickness Compensation plan, and that a report of the findings of such a study, particularly as regards the medical phases of the programs, be submitted to each of the constituent state medical societies before January, 1947, and

WHEREAS such a complete study report has never been made to the state medical societies in accordance with this action of the House of Delegates, and

WHEREAS such a study is now being made under the sponsorship of the National Physicians Committee,

THEREFORE, BE IT RESOLVED that the Rhode Island Medical Society, being well aware of the far-reaching effects of a program of compulsory cash sickness compensation, express its dissatisfaction that the study it requested of the American Medical Association has not been made, and is now being undertaken by an organization neither authorized nor qualified to speak for the American Medical profession.

The resolution was adopted.

The House of Delegates meeting was adjourned at 11:20 p.m.

Respectfully submitted,

MORGAN CUTTS, M.D., *Secretary*

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DISTRICT MEDICAL SOCIETY MEETINGS

KENT COUNTY MEDICAL SOCIETY

The April meeting of the Kent County Medical Society was held on the sixth at 8:30 p.m. at the headquarters of the Kent County Memorial Hospital Drive, 10 St. John Street, West Warwick, Rhode Island.

Minutes of the previous meeting were read and accepted.

Two candidates, Doctors Peter Koch and Carl E. Anderson, both of West Warwick, were admitted to Society membership.

Dr. Jeannette Vidal, President, proposed a joint fall meeting with members of the Kent County Dental Group for discussion of mutual problems. With the Kent County Memorial Hospital now a physical probability in the near future, this suggestion was favorably considered and so voted.

Dr. Vidal further suggested a medical society sponsored dinner-dance be held in conjunction with the medical auxiliary. This idea was popular but was tabled for later discussion relative to time and place.

The meeting was brought to early adjournment at 9 p.m. as members present were to meet the Memorial Hospital Drive directors the same evening.

Respectfully submitted,

FRANCIS D. LAMB, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was called to order by the President, Dr. Earl J. Mara, at 7 p.m., April 29, 1948, in the Nurses Dining Room of the Memorial Hospital.

The minutes of the previous meeting were read by the Secretary and accepted as read.

The following resolution was introduced and unanimously passed:

WHEREAS, we have learned through the press and radio that Dr. Francis B. Carroll, Veterans' Administration Director for New England, has named a dean's committee to correlate the medical services of the Veterans' Hospital and Teaching Program of Brown University,

WHEREAS, said appointed committee is contrary to and in disagreement with a prior committee duly elected by the House of Delegates of the Rhode Island Medical Society, after the various hospitals in the state had submitted nomination,

BE IT RESOLVED, that the members of the Pawtucket Medical Association, duly assembled,

(1) Reaffirm our faith in the democratic process of government, both within and without our organization,

(2) Reaffirm our faith in the ability of the Committee duly elected by our policy making body, the House of Delegates, of the Rhode Island Medical Society,

(3) Feel strongly that members who have accepted positions on Dr. Wriston's committee, having prior knowledge of the wishes of the Rhode Island Medical Society, have acted most unwisely,

(4) Urge the House of Delegates to reaffirm its stand and support the duly elected committee of the Rhode Island Medical Society,

(5) Instruct delegates of the Pawtucket Medical Association to vigorously oppose any change in the Rhode Island Medical Society committee as now constituted,

BE IT FURTHER RESOLVED, that copies of this resolution be sent to the Secretary of the Rhode Island Medical Society, all district medical societies, all hospital staffs of the state, and Dr. Carroll.

EARL J. MARA, M.D., *President*

Pawtucket Medical Association

Following a motion by Dr. G. Raymond Fox, the Chair appointed the following members to work with the director of the Rhode Island Cancer Committee: Doctors G. Raymond Fox, Chairman; Dr. Frank Hanley; Dr. Hrad Zolmian.

The members then adjourned to the Nurses' Auditorium where Dr. Frederick Webster, Chairman of the evening introduced Dr. Frank C. Hamm, Chief of Urology, Brooklyn Hospital, Brooklyn, New York.

Dr. Hamm's topic was "Results in the Treatment of Prostatic Hypertrophy." He included a report of the management of 207 cases and a comparison of.

continued on next page

1. Suprapubic Prostatectomy
2. Retropubic Prostatectomy
3. Transurethral Resection.

Dr. Chapian, Dr. Sprague, Dr. Chaset discussed Dr. Hamm's paper and the meeting adjourned at 9 p.m.

Thirty-two members attended.

Respectfully submitted,
KIERAN W. HENNESSEY, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Library on Monday, May 3, 1948. The meeting was called to order by President Philip Batchelder at 8:30 p.m.

With the consent of the membership the reading of the minutes of the previous meeting was omitted.

The Secretary presented a communication from the St. Joseph's Hospital inviting the members of the Providence Medical Association to attend a staff meeting there on Tuesday, May 25, at which Dr. Edward J. Waters of Jersey City was scheduled to address the group.

The Secretary reported for the Executive Committee as follows:

1. It was recommended that the annual dinner and golf tournament for the members of the Association be held, if possible, the first or second Wednesday after Labor Day.

2. Approved of the recommendation of the Committee on Pre-School Examinations that "Parents of children of pre-school age be provided with examination forms and be encouraged to have the examinations made by the family physician." But withheld approval of these commendations that:

   "Arrangements be made for the examinations of those who do not have private service at some schools, in which case they would be done by the school physicians with the school nurse present" and that the executive secretary of the Association "provide a list of names of local younger physicians who would be willing for reasonable compensation to serve in the event the school physicians are not available."

The Executive Committee authorized the President to confer further with members of the Association and the Committee on this matter.

3. Authorized the President to name a committee to re-open the study of health and accident insurance for the members of the Association.

It was moved, seconded and adopted that the report of the Executive Committee be approved.

Dr. Philip Batchelder made the following announcements:

The Committee of Dr. John Ferguson and Dr. Joseph C. O'Connell has submitted the Association's tribute to the late Dr. Charles E. Hawkes and the committee of Dr. Albert H. Jackvony and Dr. Edwin B. O'Reilly presented the tribute to the late Dr. Patrick I. O'Rourke.

As a committee to prepare the Association's tribute to the late Dr. Fred Coughlin the following are named: Drs. James J. Hamilton and James F. Boyd.

Dr. Batchelder introduced as the first speaker of the evening Dr. Jesse P. Eddy, III, Senior Assistant Surgeon, the Memorial Hospital, Pawtucket, who spoke on the subject "Bilateral Non-Simultaneous Femoral Arterial Occlusion".

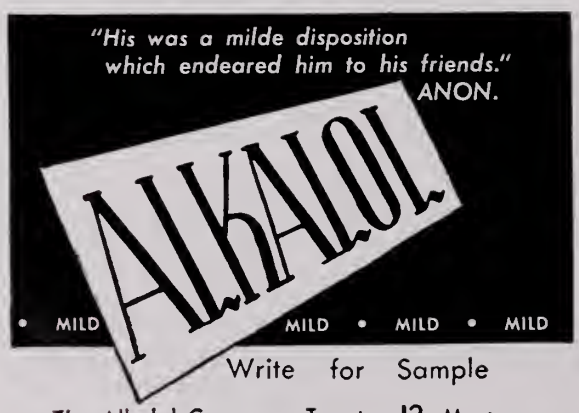
Dr. Eddy presented a case report with a brief review of some local experiences and deductions in embolic disease of arteries. His patient, a cardiac with fibrillation, experienced a sudden cold leg. The patient had cyanosis to the thigh and a feeble femoral pulse. The clot was removed by operation. Anticoagulants were also used. The pulse returned to the leg.

Four days later, the patient experienced a similar episode in the left leg. This was similarly treated and the patient recovered.

Dr. Ralph DiLeone, Assistant Surgeon, Department of Gynecology, Rhode Island Hospital, and Dr. Ralph E. Brown, Resident in Surgery, Rhode Island Hospital, were the second speakers of the evening discussing "Carcinoma of Cervical Stump Following Supravaginal Hysterectomy".

Dr. DiLeone stressed the increasing number of carcinomas of the cervical stumps following supracervical hysterectomy. This fact has led gynecologists to do total hysterectomy instead of the incomplete operation. Totals can now be done safely with as low a mortality rate as the supercervical.

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PROVIDENCE MEDICAL ASSOCIATION

concluded from page 398

The mortality rate for total hysterectomy now is 0.2% to 0.8%.

Prior to 1934, only 18% of hysterectomies were total. Now the total operation is in the neighborhood of 65%. In 1945, at the Rhode Island Hospital total hysterectomy was performed on most patients. Of 320 totals done at the Rhode Island Hospital, no deaths resulted.

The incidence of carcinoma of the stump ranged from 2.5 to 11.3%. It is 4% at the Rhode Island Hospital. Another argument for total hysterectomy is that carcinoma of the cervix is four times more frequent in patient who have uterine fibroids. This carcinoma appeared as a rule within three years of the operation. The five year survival rate of those treated for carcinoma of the stump is comparable to those treated with intact uteri. A patient with a remaining cervical stump should report for frequent examinations.

The paper was briefly discussed by Dr. Pitts who stated that for thirty years he has not done a supracervical operation, but all total hysterectomies.

The final paper, by Dr. Howard Haggard, Director, Laboratory of Applied Physiology, New Haven, was on "Alcoholism".

Dr. Haggard feels he is now getting the public to see that alcoholism is a medical problem. About sixty million people use alcohol with no harm. About three million use it to excess. He divides these into groups.

Group 1. Symptomatic Drinkers. Fifteen to twenty per cent of the cases. They suffer from endocrine disturbances, psychoses, or epilepsy, and drink because of these ailments. In these cases, we should not attempt to treat their habits, but the underlying condition.

Group 2. Socially ill. These are not sick physically or mentally. They have no compulsion to drink. They get drunk for nothing else to do.

Group 3. The true alcoholic. He has an overwhelming compulsion to drink. He has a physical disturbance but we haven't discovered the cause. It is probably on a physical basis. He departs from the normal habits of drinking. Formerly the average alcoholic was forty—forty-five years of age; now we get patients in the thirty year group.

The feature that characterized him is that if he takes a drink or two, he can't stop. He has remorse afterwards as contrasted to Group 2.

True alcoholics cannot be cured. All you can get is symptomatic recovery. There is no specific therapy. A very careful physical is done first, then the remainder of the treatment falls in the realm of faith healing.

Dr. Haggard has two psychiatrists in his group but psychiatry is not used. The clinic finds out what therapy suits the particular patient and that is used. The important thing is that he be treated with the same respect you use toward a sick man.

About twenty per cent of the patients from Dr. Haggard's clinic are sent to Alcoholics Anonymous.

The meeting adjourned at 10:30 p.m.

Attendance was 105.

Collation was served.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D., *Secretary*

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IN THE EVENT OF A NATIONAL EMERGENCY

(The report below is abstracted from a special report to the House of Delegates of the Rhode Island Medical Society by Dr. Albert H. Jackvony and Mr. John E. Farrell who represented the Society at the Spring session of the Council on National Emergency Medical Service of the American Medical Association at Chicago, April 5-6, 1948)

A WHOLE NEW GROUP of special weapons—atomic bombs, biological products and chemical agents that science has made available, is projecting an unprecedented challenge to the medical profession and those associated with rendering service to the nation in the event of another war. Though war is by no means inevitable in the present world wide crisis, the very threat of it demands that the people of this country be made fully cognizant of the special weapons possible in the event of another world conflict and also that they be fully organized to cope with any disaster or national emergency that may arise.

Even the dissipation of the present threat of Communism would not warrant the acceptance of the belief that peace in our time will continue indefinitely. The atomic bomb did not merely end the war with the Japanese; it started what may be an era of great peace or of total destruction for many peoples of the world. Until people everywhere grasp the true significance of the atom bomb and allied scientific discoveries, and particularly the use of such discoveries as weapons of destruction, men in no lands may hope to resume the pattern of life that we like to call normal and peaceful.

Therefore the presentation that follows must be construed not with alarm in the sense of fear or panic, but alarm in the sense of cold reasoning of imminent danger that is intensified by the apparent lack of preparedness of this great nation which aione in the world can lead a successful defense for free men everywhere.

THE WAR THREAT

Russia is the only nation in the world today capable of waging war with the United States. The incidents that might provoke such a conflict are too well-known to require repetition or elaboration here.

But a World War III would not necessarily mean the invasion and conquest thereby of a nation. The new special weapons referred to above, and others unknown to all nations, would be employed to paralyze and even destroy the economic power of this country. The first blow would be a special weapon aimed for mass destruction and havoc. It need not be delivered by a bombing plane travelling a long distance, but could arise from the hold of a tramp steamer at dockside in any of our great seaboard cities.

The use of such a special weapon as the atom bomb, or an offspring of it, might well seal the fate of all peoples of the world. It is fairly certain that the first atom bomb is now replaced by a more modern counterpart a thousand times more powerful. Ten bombs per city, five in the air and five in the water (except at Denver) over 25 key cities of this country would destroy completely the facilities of such cities and would let loose radioactive rays in the air to contaminate wide areas for years to come. Millions of deaths could be caused by even a single bomb over 20 populous cities.

But we have the atomic bomb! True, but it is a secret that we may well question the ability of man to retain within the confines of one group of minds, or one country. And could we, or any other nation use the atomic bomb, unless the belief that war is murder and by whatever means justified, is to prevail to the end that free society faces the threat or even the reality of annihilation?

ATOMIC WARFARE

While the possession of the atomic bomb secret is undeniably of tremendous psychological warfare value to us, it is to be regretted that the American people have so little information about the literally fantastic features of this scientific discovery which is thought more of in terms of its destructive power than for its peaceful use. The speakers at the conference divulged little that is probably new information about the scope of atomic energy for a scientist or physician. All speakers stressed the importance of public education, and the need for adequate agencies to compile, analyze and disseminate information on atomic energy outside the Atomic Energy Commission, preparing suitable literature, text books, etc.

The inherent threat in the possible misuse of atomic energy demands constant vigilance and ef-

continued on next page

fective civil defense. The role of the medical profession in such vigilance and defense will be paramount. The exercise of great care and preparation in the training of personnel resulted in no casualties at either the Manhattan project or in the post-war Pacific experiments with the atom bomb. Civil defense will require the same precautions, hence medicine must first undertake the task of educating its membership in the ramifications of atomic energy.

The devastating effect of the atomic bombings in Japan, related in press and in public meetings since the end of the war, was repeated by several of the speakers. Some of their comments bear repeating. The gamma radiation equalled several thousand tons of radium, and in the water experiment it was estimated that there was from one to a hundred tons of radium in the mist which in great part could be wind-blown to distant shores, thus constituting a continuing hazard of contamination. This latter point was forcibly brought out with the illustration that cumulus clouds loaded with radioactive substances might well circle the globe, dropping their deadly cargo in widely scattered localities, even to the extent of contaminating ground, thus affecting the food supply now and for future generations.

Likewise the contamination from a water explosion could wreak equal havoc on the world. For example, the illustration was offered that a bomb in Lake Michigan could contaminate the water down to the mouth of the St. Lawrence, thence into the fishing banks off New Foundland, thereby seriously affecting the fish food supply of the nation.

In an air detonation the heat and fire of the bomb are blown out by the accompanying blast which in turn adds to the devastation as was evidenced at Hiroshima. Cities are weak at their roof tops, hence the crumbling of structures was immediate, and the flying debris added to the toll of casualties. Death from the blast occurred in the first 24-48 hours, and within the first week the serious effects of gamma radiation is evidenced with the gastro-intestinal tract most seriously damaged; later the disintegration affects the bone marrow. Thus all persons living after such an explosion must be screened to check the evidence of radiation.

The extent to which the civilian population must be educated and trained in its own defense and care is best illustrated by the fact that at Hiroshima 260 out of the 300 available physicians were killed or injured, 75% of the nurses and technicians suffered similar fates, and all the hospitals and public utilities were destroyed.

In the light of even these few salient views can there be any question of the need for an alert civil defense for a national emergency in general, and a war involving special weapons in particular?

CIVIL DEFENSE

The Civil Defense Board, advisory to the Secretary of Defense, has already been established with Russell J. Hopley as its director to draft a national program. The functions of this organization will include the preparation of a defense program calling for permanent organizations, the initiation of interim measures for civil defense while legislation is pending to set in motion definite plans, the possible establishment of training centers where monitors will be educated in a radiological defense system, and the preparation in general for a national disaster with complete inventory of emergency medical and hospital and allied facilities.

The Civil Defense Board is apart from the War Department, and it also will not interfere in any manner with the National Resources Advisory Planning Board which still has jurisdiction over the allocation of essentials including manpower.

Medicine is expected to take leadership in planning to aid on the medical implications of radio active substances, educating both its own membership and the public. Physicians would join with other scientists in training technicians in the use of instruments to detect radio activity, and would in general set up active committees within their societies for emergency administration available to answer a call from the government in a national emergency.

Dr. Bortz, president of the American Medical Association, reported on the study of an atomic energy sterring committee of the Philadelphia County Medical Society which supported a plan that communities be regionally divided with certain major groups within each responsible for definite restricted duties. These groups, as outlined by the Philadelphia committee are as follows:

Group One: Monitors. This assignment included the appointment of persons qualified to utilize the



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new instruments of precision for the identification of radioactive substances.

Group Two: For blood and blood substitutes
Group Three: Psychiatry (morale)
Group Four: Emergency Administration
Group Five: Epidemiology
Group Six: Education and Public Relations

* * *

There is no presently known method of protecting those in the immediate neighborhood of an atomic bomb when it explodes. Nevertheless, since the Los Alamos experiment opened the Atomic Age, a great deal has been learned about mitigating the secondary effects of ionizing radiation and about protecting survivors who have received less than a lethal dose.

Many lives may be saved by widespread knowledge of therapeutic measures among physicians, and many more by a general understanding of preventive measures which can be taken by the general population.

The real difference between ordinary high explosives and atom bombs in the enormous amount of radiant energy produced by the latter—energy covering the whole range of wave lengths from heat waves to million-volt gamma waves.

The radiant energy may be divided into two types: ionizing and non-ionizing. The most important type of injury noted in Hiroshima and Nagasaki was, of course, that due to the ionizing compenent of the radiant energy from the bomb. Four known kinds of penetrating radiation can be expected within the immediate area of the blast. They are:

First, gamma radiation, which is essentially the same as x-ray. In an atom bomb explosion, however, these are 200,000,000 volt x-rays. They are lethal to anyone within roughly a mile of the blast, do serious damage to those as close as a mile-and-a-half, but their range is limited to approximately two miles. They move with the speed of light and most of them are produced at the instant of explosion.

Second, neutron beams, streams of heavy atomic particles shot out in all directions within a millionth of a second of the explosion. They have slightly less range than gamma rays. Both gamma rays and neutron beams passing through matter such as blood, bone or flesh, produce extensive ionization of the atoms which made up body cells, which results in the breakdown of chemical bonds, causing profound alterations in cellular function. The fact that some kinds of cells, such as certain types of cancer cells, are affected more easily than others is the basis of radiation therapy. Whatever damage is done in this way is instantaneous, although observable symptoms may not appear for some time.

continued on next page

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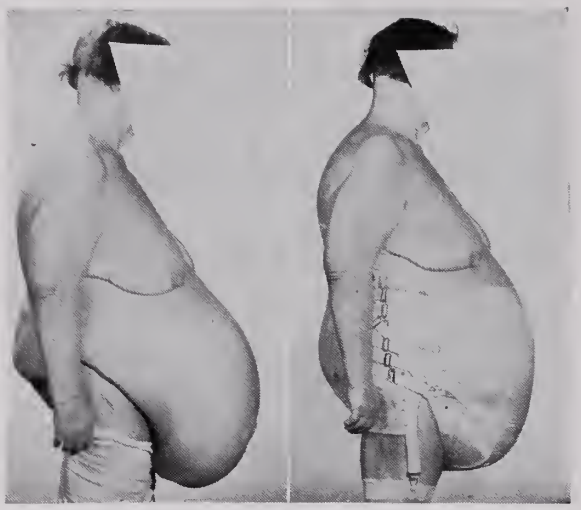
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IN THE EVENT OF A NATIONAL EMERGENCY

continued from preceding page

Neutron beams, however, have another effect, new in medical science. Neutrons are captured in elements contained in human cells, producing new elements which are themselves radioactive, and may remain so for a long time.

Third, are beta rays, streams of electrons which rarely penetrate the skin and whose effects will be found chiefly on the surface; and,

Fourth, are alpha particles, the nucleii of helium atoms, which do not get through the cornified, or horny tissue, layer of the skin. Because of their low penetrating power, it is not likely that either the beta rays or the alpha particles resulting directly from the explosion will cause fatal injury.

There is not much even a medical man can do about the immediate radiation from an atom bomb explosion. But in such an eventuality the immediate requirement will be for rescue work on a large scale and treatment for fractures, contusions, lacerations and burns. Here physicians and laymen will be on familiar ground.

Also, some aid may be given to victims of many sorts of secondary radiation dust spread by the explosion, radioactivity cause by neutron captured by atoms, or radioactive spray if the bomb is dropped in water. Against this secondary radiation, various safeguards can be provided, and it is essential that physicians be trained in safety measures. Army, Navy and Atomic Energy Commission scientists, as well as civilians interested in radiation therapy, are hard at work on the problem and substantial progress is being made. One important line of research is in the efficacy of blood transfusions, since it has been established that one of the most serious effects of radiation is damage to the blood-forming elements such as the bone marrow. A person tided over until normal function is resumed may be saved.

A major function of the physician after such a disaster would be to act as public health officer. Most food in the affected area would not be unfit for consumption, but it would all have to be surveyed before it could safely be eaten. All the water in the region would probably contain radio-active isotopes, slow poison to anyone drinking it, but research is in progress on methods of removing radioactive substances. Obviously the usual boiling or chlorination would be useless. There is some indication that filtration and other methods can be developed.

Physicians would have a heavy responsibility in supervising the decontamination of not only food and water but of refugees, by means of complete change of clothing, bathing, etc. This requires familiarity with the use of detecting instruments

continued on page 406

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IN THE EVENT OF A NATIONAL EMERGENCY

concluded from page 404

such as the Geiger counter, and a knowledge of the kinds of persistent radiation to be expected. (People escaping from the area where a bomb has exploded may find their wearing apparel sufficiently radio-active to constitute a menace to others.) This problem has already come up in hospitals where patients are being treated with large amounts of radio-active material.

Besides flash burns from enveloping hot gases, such as result from any powerful explosion, blisters similar to skin burns and sunburn are likely to appear on the skin of atom bomb victims. In Japan, burns and blisters appear to follow a definite pattern, showing up within five minutes on those close to the explosion. At nearly a mile away, they did not show for several hours, and at greater distances, up to about two miles, the appearance of burns and blisters was even longer delayed.

Of the superficial effects perhaps the most alarming is the falling out of the hair. While bound to cause a bad psychological effect, it is due to superficial radiation and is not serious in itself. The hair will return if the patient has not received a lethal dose of radiation.

Immediately after a bomb blast those in the vicinity who escape immediate death from shock, burns or falling debris may appear to have suffered no ill effects at first. But within a few hours, victims seriously affected will feel nauseated and start to vomit. This may pass in a day or so. But at the beginning of about the second week when the hair starts to fall out, the feeling of general malaise, experienced in the first few hours, may return accompanied by fever. There is likely to be bloody diarrhea. Examination will show that the white blood count has fallen to a very low level. Death may come very quickly, or there may be anemia and general debility over a long period with eventual recovery.

Physicians must be prepared to expect such a syndrome and to take nothing for granted about the condition of the patient during the first few days.

There is a parallel in our experience with heavy bombing of cities from the air in World War II. This type of warfare was an innovation, and at first physicians had virtually no information concerning the effect of shock waves of that magnitude on the human body. Scores of people in the neighborhood of bursting bombs died, although they had apparently suffered no injuries. The knowledge of what could be done to save those people was acquired the hard way because medical science had not foreseen such a problem.

The threat of the atom bomb is at least now recognized and we have already a growing body of knowledge which can be mastered while an emergency is still remote.

WOMAN'S AUXILIARY
to the
RHODE ISLAND MEDICAL SOCIETY

REPORT OF MARCH MEETING

A meeting of the Woman's Auxiliary to the Rhode Island Medical Society was held on March 4, 1948, at the Rhode Island Medical Library. Mrs. Herbert E. Harris, President of the Auxiliary, called the meeting to order at 2:00 p.m. In a few opening remarks Mrs. Harris told the group of the purpose of the Auxiliary.

The Secretary, Mrs. Charles L. Farrell, read her report. It was approved.

The Treasurer, Mrs. Jesse P. Eddy 3rd., reported a balance on hand of $571.31 with a membership of over two hundred.

The Secretary read a news letter from Mrs. Eustace A. Allen, President of the National Woman's Auxiliary.

Mrs. Herman A. Lawson reported for the Legislative Committee. They recommended that their Committee be enlarged.

Plans for extension of our membership campaign were outlined by Mrs. Bertram H. Buxton and Mrs. Joseph C. Kent of the Organization Committee.

In the absence of Mrs. Henry S. Joyce, Chairman of the Revisions Committee, Mrs. Arcadie Giura reported for that Committee. She stated that they were continuing their work on the Revisions of the By-Laws and were making progress.

The Program Chairman, Mrs. Charles F. Gormly, detailed her Committee plans for the Annual Meeting to be held on May 12, 1948, at the Plantations Club. Luncheon will be served at 12:30 p.m.

The business meeting adjourned at 2:45 p.m.

Our President, Mrs. Harris, introduced Dr. Arthur H. Ruggles, President of the Rhode Island Medical Society. Dr. Ruggles stated that the Woman's Auxiliary plays a great part in promoting public relations.

He then introduced the speaker of the afternoon, Dr. Edward A. McLaughlin, Director of Health for the State of Rhode Island. Dr. Ruggles paid tribute to Dr. McLaughlin's ability as a Public Health Administrator.

Dr. McLaughlin congratulated the Woman's Auxiliary on their formation and work and stated that they would stimulate interest in medical practice and medical care. He also feels that public health, medical care and the practice of medicine, are closely allied.

He then outlined the growth of the State Health Department.

Thirteen years ago the budget of the State Health Department was $130,000 with 8 nurses and 52 employees. Today the budget is $775,000 with 35 nurses, 172 full-time, and 85 part-time workers. The department is divided into fifteen organization units or bureaus.

The present functions of the Rhode Island State Health Department are:

1) To provide a complete public health program at State Level.
2) To take all action necessary for the protection of the lives and health of the citizens of the State.
3) To correlate the public health activities of all federal, state, municipal and private agencies in so far as they deal with matters of public health in Rhode Island.

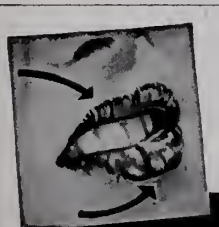
As national programs have been developed it is apparent, Dr. McLaughlin stated, that "Public Health Services are entering into the realm of private health".

Commenting on the situation regarding hospitals, Dr. McLaughlin stated that at the present time those institutions faced with greatly diminished income and smaller endowments seem to have no alternative other than federal aid. Following the address the speaker answered questions from the audience.

The meeting adjourned at 4:00 p.m.

Respectfully submitted,

MARY A. FARRELL, *Secretary*


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SECOND ANNUAL CONVENTION

Woman's Auxiliary to the Rhode Island Medical Society

The second Annual Luncheon Meeting of the Woman's Auxiliary to the Rhode Island Medical Society was held in the Auditorium of the Plantations Club on May 12, 1948, at 12:30 p.m.

Dr. Arthur H. Ruggles, President of the Rhode Island Medical Society, extended greetings to the Auxiliary from the Rhode Island Medical Society. He congratulated the Auxiliary on the progress in its first year, and urged the women to cooperate with the local community to bring about greater improvements in pollution control in Rhode Island.

He asked their aid in creating public opinion for better laws for the preparation and distribution of milk.

Mrs. Herbert E. Harris, President of the Auxiliary, presented a gavel to the Auxiliary.

Mrs. Robert Flanders brought greetings from the New Hampshire Auxiliary.

Our guest speaker of the day, Mrs. Luther H. Kice of Garden City, Long Island, President-Elect of the Woman's Auxiliary of the A. M. A., spoke at length on the work of the National organization.

Following the luncheon a business meeting was held.

The Secretary's report was read and a motion was made by Mrs. Edgar Potter and seconded by Mrs. Waldo Hoey that the report be accepted. Motion carried.

The Treasurer, Mrs. Jesse P. Eddy 3rd, reported a balance on hand as of April 30th of $801.58 with a membership of 237. A motion was made by Mrs. J. Merrill Gibson and seconded by Mrs. Joseph C. Johnston that this report be placed on file. Motion carried.

It was moved by Mrs. Paul Cook and seconded by Mrs. William Davis that the reports of the Standing Committees be accepted as a unit.

Mrs. Bertram H. Buxton of the Organization Committee reported an increase of 61 members for the year.

Mrs. Herman Lawson reported for the Legislative Committee.

Mrs. J. Lincoln Turner reported for the Editorial Committee.

Mrs. Charles F. Gormley reported for the Program Committee.

Mrs. William N. Hughes reported for the Revisions Committee.

In the absence of Mrs. James P. O'Brien the Secretary read the report of the Public Relations Committee.

Mrs. Henry Hanley moved that these reports be accepted as a unit. Mrs. H. Lorenzo Emidy seconded the motion. Carried.

Mrs. Guy Wells, Vice-President, took the chair while Mrs. Herbert E. Harris, President, read her report. Mrs. Harris urged the Auxiliary to consider a nurses Scholarship Fund as a project.

A motion was made by Mrs. Bertram H. Buxton and seconded by Mrs. Edgar Potter that this report be accepted. Motion carried.

Election of Delegates to the Woman's Auxiliary of the A. M. A. followed. Mrs. Charles Ashworth and Mrs. Jesse P. Eddy 3rd were elected as Delegates. Mrs. Peter Pineo Chase amended that anyone else going should be made alternates.

Our Delegates were instructed to vote in favor of the increase in dues.

A motion that these Delegates be accepted was made by Mrs. Henry Hanley and seconded by Mrs. Robert T. Henry.

The President stated, prior to the submission of the Nominating Committee's report, that there could be counter nominations from the floor. She then desired to know the feelings of the members regarding balloting in such an event. A motion was made by Mrs. John J. Donley and seconded by Mrs. Bertram H. Buxton that in such an event the election be made by ballot. Carried.

Mrs. Paul Cook, Chairman of the Nominating Committee read the report of her Committee:

Mrs. J. Murray Beardsley—President
Mrs. Charles L. Farrell—Vice-President
Mrs. William Newton Hughes—President-Elect
Mrs. Henry J. Hanley—Secretary
Mrs. Jesse P. Eddy 3rd—Treasurer

continued on next page

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Bristol—Mrs. Arcadie Giura
Kent—Mrs. Joseph C. Kent
Washington—Mrs. Joseph H. Ladd

The President asked for further nominations from the floor.

As there were no counter nominations, Mrs. Niles Wescott moved that these officers be elected. Mrs. Frank Hanley seconded the motion. The motion was carried. The Secretary cast one ballot electing these officers.

Mrs. Herbert Harris presented the gavel to the new President, Mrs. J. Murray Beardsley, and wished her and the organization a successful year.

Changes in By-Laws submitted by the Revisions Committee were then voted upon. A motion was made by Mrs. Henry Hanley and seconded by Mrs. H. Lorenzo Emidy that these revisions be accepted. Motion carried.

Next in order of business were the nominations and election of members of the 1949 Nominating Committee. Mrs. H. Lorenzo Emidy and her Committee of tellers checked the ballots. There were several nominations from the floor. The results of this Committee will be announced after the next Board meeting.

The meeting adjourned at 3:40 p.m.

Respectfully submitted,
MARY A. FARRELL, *Secretary*

RECORD LIBRARIANS ELECT

At the business meeting of the Rhode Island Association of Medical Record Librarians held during the annual meeting in May, the following officers were elected:

President: Miss Barbara Arnold of Roger Williams General Hospital

Vice President: Miss Olivia Brum, of Lying-In Hospital

Secretary: Miss Jane Lowe, of Lying-In Hospital

Treasurer: Miss Eleanor Murphy, of Rhode Island Hospital

Councillors: Miss Mary Nunez, of Pawtucket Memorial Hospital

Miss Sarah Litwin, of Miriam Hospital

INDEX OF ADVERTISERS

	PAGE
Abbott Laboratories	353
Alkalol Company	398, 402
Ames Company, Inc.	392
E. P. Anthony, Inc.	396
Ar-Ex Cosmetics, Inc.	407
Arlington Chemical Company	350
Ayerst, McKenna & Harrison	357
Bayview Convalescent Home	396
Blanding & Blanding	362
Borden Company	360
J. E. Brennan & Company	411
George A. Breon and Company	387
Joseph Brown Company	411
Buffington's, Inc.	386
Butterfield Drug Stores	408
Camel	356
S. H. Camp Company	351
Ciba Pharmaceutical Products, Inc.	349, 383, 399
Coca-Cola	393
Curran and Burton	400
Davies, Rose & Company	Inside Front Cover
Doho Chemical Corp.	389
Edgewood School	400
J. E. Hanger, Inc.	393
Langlais Health Institute	390
Eli Lilly & Company	Insert between 362-363
McCaffrey, Inc.	371
Mead Johnson & Company	Back Cover
Medical Milk Commission	387
Merck & Company	359
Meredith & Clarke, Inc.	395
A. B. Monroe Dairy	403
Mutual Benefit Health and Accident Association	352
Neland Pharmaceutical, Inc.	393
Owens-Corning Fiberglas	385
Parke, Davis & Company	381
	Inside back cover
Physicians Directory	405-406
Rhode Island Limb Company	394
Schering Corporation	391
G. D. Searle & Company	379
Smith-Holden, Inc.	354
Spencer, Inc.	404
Tilden-Thurber	395
Wander Company	358
White Rock Bottling Company of Rhode Island	394
Winthrop-Stearns, Inc.	361

APPOINTED COMMITTEES — 1948-49

The Rhode Island Medical Society

Committee on Cancer

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Joseph C. O'Connell, M.D., Providence
William Fain, M.D., Providence
Henry B. Moor, M.D., Providence
E. Victor Conrad, M.D., Providence
G. Raymond Fox, M.D., Pawtucket
James C. Callahan, M.D., Newport
James McCarthy, M.D., Woonsocket
Frank E. McEvoy, M.D., Providence
Herman C. Pitts, M.D., Providence
Isaac Gerber, M.D., Pawtucket
Adolph Eckstein, M.D., Providence
John Paul Jones, M.D., Wakefield
B. Earl Clarke, M.D., Providence
Hartford P. Gongaware, M.D., Westerly
Philip Batchelder, M.D., Providence

Committee on Child Health Relations

Earl F. Kelly, M.D., *Chairman,* Pawtucket
Henry E. Utter, M.D., Providence
Francis V. Corrigan, M.D., Providence
Harold G. Calder, M.D., Providence
Merle M. Potter, M.D., Providence
William P. Buffum, M.D., Providence
Jose M. Ramos, M.D., Newport
Isadore Gershman, M.D., Providence
Reuben C. Bates, M.D., Providence
Reginald A. Allen, M.D., Providence

Committee on Maternal Health

John G. Walsh, M.D., *Chairman,* Providence
Michael H. Sullivan, M.D., Newport
George E. Bowles, M.D., Providence
Alfred L. Potter, M.D., Providence
John F. Murphy, M.D., Providence
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Louis A. Morrone, M.D., Westerly
Henry E. Turner, M.D., Pawtucket

Committee on Medical Defense and Grievance

Roland Hammond, M.D., *Chairman,* Providence
Fenwick G. Taggart, M.D., East Greenwich
Robert H. Whitmarsh, M.D., Providence
John F. Kenney, M.D., Pawtucket
Henri E. Gauthier, M.D., Woonsocket
Michael H. Scanlon, M.D., Westerly
Robert G. Murphy, M.D., Providence
Albert H. Jackvony, M.D., Providence
Charles J. Ashworth, M.D., Providence
Adolph W. Eckstein, M.D., Providence

Committee on Vocational Rehabilitation

Henry J. Hanley, M.D., *Chairman,* Pawtucket
Vincent J. Ryan, M.D., Providence
Albert H. Jackvony, M.D., Providence
Robert H. Whitmarsh, M.D., Providence
Herbert E. Harris, M.D., Providence
Emanuel Benjamin, M.D., Providence
William M. Muncy, M.D., Providence
James P. Deery, M.D., Providence

Committee on Social Welfare

Peter F. Harrington, M.D., *Chairman,* Providence
Earl J. Mara, M.D., Pawtucket
John H. O'Brien, M.D., East Providence
Thomas A. Nestor, M.D., Wakefield
Rocco Abbate, M.D., Lakewood
William O. Rice, M.D., Howard
Jose M. Ramos, M.D., Newport
Henry S. Joyce, M.D., East Providence
Harold W. Williams, M.D., Providence
David G. Wright, M.D., Providence

Committee on Tuberculosis

John C. Ham, M.D., *Chairman,* Providence
Philip Batchelder, M.D., Providence
Louis I. Kramer, M.D., Providence
Peter F. Harrington, M.D., Providence
U. E. Zambarano, M.D., Wallum Lake
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Joseph N. Corsello, M.D., Providence
John I. Pinckney, M.D., Providence
Herbert F. Hager, M.D., Providence

REPORT ON THE AMERICAN ACADEMY OF PEDIATRICS CHILD HEALTH SERVICES STUDY

As the Rhode Island Medical Society contributed to the Child Health Service Study and as we earnestly desire its advice and approval, we are presenting a progress report.

The study consists in the collection of data, the tabulating of these data at the Academy national headquarters and then the presentation of the material by the Rhode Island members to the interested parties with critical analysis and recommendations.

The figures are grouped in four categories comprising the child health activities of medical schools, hospitals, public health agencies and organizations, and private physicians. The medical school study is on a national basis. This study was made by agents from the Academy Headquarters. The recommendation for government subsidy for medical schools is a highly controversial subject but as there are no medical schools in Rhode Island, the Rhode Island members of the Academy will not touch upon that in their report.

The study of the other three groups of figures, those on hospitals, public health agencies and organizations, and private physicians is the responsibility of the Rhode Island members of the Academy. The central office has tabulated the figures which we collected and is sending them to us for presentation. We are entirely independent in this and can be subjected to no pressure whatsoever from outside the state.

Dr. Henry E. Utter has accepted the chairmanship of the subcommittee on child care by private physicians. Dr. Harold S. Calder has accepted the chairmanship of the subcommittee on public health agencies and organizations and Dr. Banice Feinberg has accepted the Chairmanship of the subcommittee on hospitals. These chairmen will form committees of academy members and invite other persons who have special knowledge in the field to sit in with them at committee meetings.

In these subcommittee meetings the figures will be arranged to show their significance and if there are any wise recommendations which can be made they will also be presented. The Academy members will form the main committee and will present the report and be responsible for it.

If our report is to be of value it must have the approval of the medical profession in the state. We urge anyone who does not understand or who has any criticism of our study to let us know his ideas about it. We shall keep the Rhode Island Medical Society informed of our progress from time to time.

It is impossible to say at this time how revealing or how valuable our report will be but you can be assured that we shall not make any recommendations for child health care without very careful consideration.

William P. Buffum, M.D.,
Chairman for Rhode Island
American Academy of Pediatrics

April 26, 1948

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BOOK REVIEWS

SYMPOSIUM ON MEDICOLEGAL PROBLEMS. Edited by Samuel A. Levinson, M.D., PH.D., University of Chicago College of Medicine. *J. B. Lippincott Company, Publishers.*

This book of 249 pages is a review of meetings of the Institute of Medicine of Chicago and the Chicago Bar Association. The contents bring out, as the foreword states, "Because of the education and training that is given to the members of both professions and the opportunities inherent in their practice, they very clearly have a public duty to perform in the community. Those duties . . . extending into public welfare generally."

Among the problems discussed are Expert Testimony, The Medicolegal Implications of Artificial Insemination, The Medicolegal Problems of Pathology, Medicolegal Implications of Operations to Produce Sterility, Trauma in the Causation of Tumor, Blood Grouping in Paternity Cases, Chemical Tests for Intoxication.

The scientific presentation is made by medical men or men skilled in a scientific field and the legal viewpoint is presented by men learned in jurisprudence.

The presentations are excellently given and the legal viewpoint is excellently stated. The question periods allowed at the end of the presentations bring out diverse viewpoints, all of which are provocative of further thought.

The thing the scientific presentation seems to miss can be adequately expressed by the words of the late Justice Holmes viz: "The life of the law is not logic but experience". Experience frequently demands that we accept what is expedient rather than what is logical. However science may gradually disclose how logic and expediency may be more frequently reconciled.

The clash of the numerous private and social interests is well demonstrated. The natural bias of attorneys representing individual interests as against corporate and state interests is obvious in the questions put to the speakers.

Throughout the book it is ideal that there is full and open discussion — without thought of embarrassment by putting the other fellow "on the spot."

Of course, the whole field of medicolegal matters is not covered. To do so would take volumes. The present monograph, however, is an excellent beginning and might well serve as a model for future symposia conducted by the medicolegal associations of the several states.

J. Francis Daurman has finely prepared a foreword. The publishers have made the format of the book such that it is readable without fatigue. The speakers and their questioners have well discussed the problems presented and have left the reader with plenty of material for consideration.

Whether one appears in court or not, whether one is vitally interested in the subjects presented or not, the book is recommended for its stimulation of thought and also to show the practical difficulties that beset the reconciliation between that which is logic and/or expedient.

WILLIAM H. FOLEY, M.D.

"THE BATTLE OF THE CONSCIENCE"

by Edmund Bergler, M.D.—Published 1948.

Washington Institute of Medicine,

Washington, D. C.

This book discusses the conscience from the psychoanalytic viewpoint. The fact that much of the conscience is formed from the child's idea of what the authorities of childhood—chiefly the parents —desire, demand, and approve is well presented. This book stresses that there is no appreciation of the real difficulties or possibilities of life or of its limitations during the origin of conscience. It also emphasizes that guilt or dissatisfaction tends to occur when facts and your "conscience-concept" of yourself show a discrepancy. In other words your self-erected conscience gives you guilt for not achieving its goals.

The language and theories of the book were not easy for the reviewer to follow or understand. A person psychoanalytically trained might profit from reading the book. A person not psychoanalytically trained would probably gain little inspiration or insight.

WILLIAM NEWTON HUGHES, M.D.



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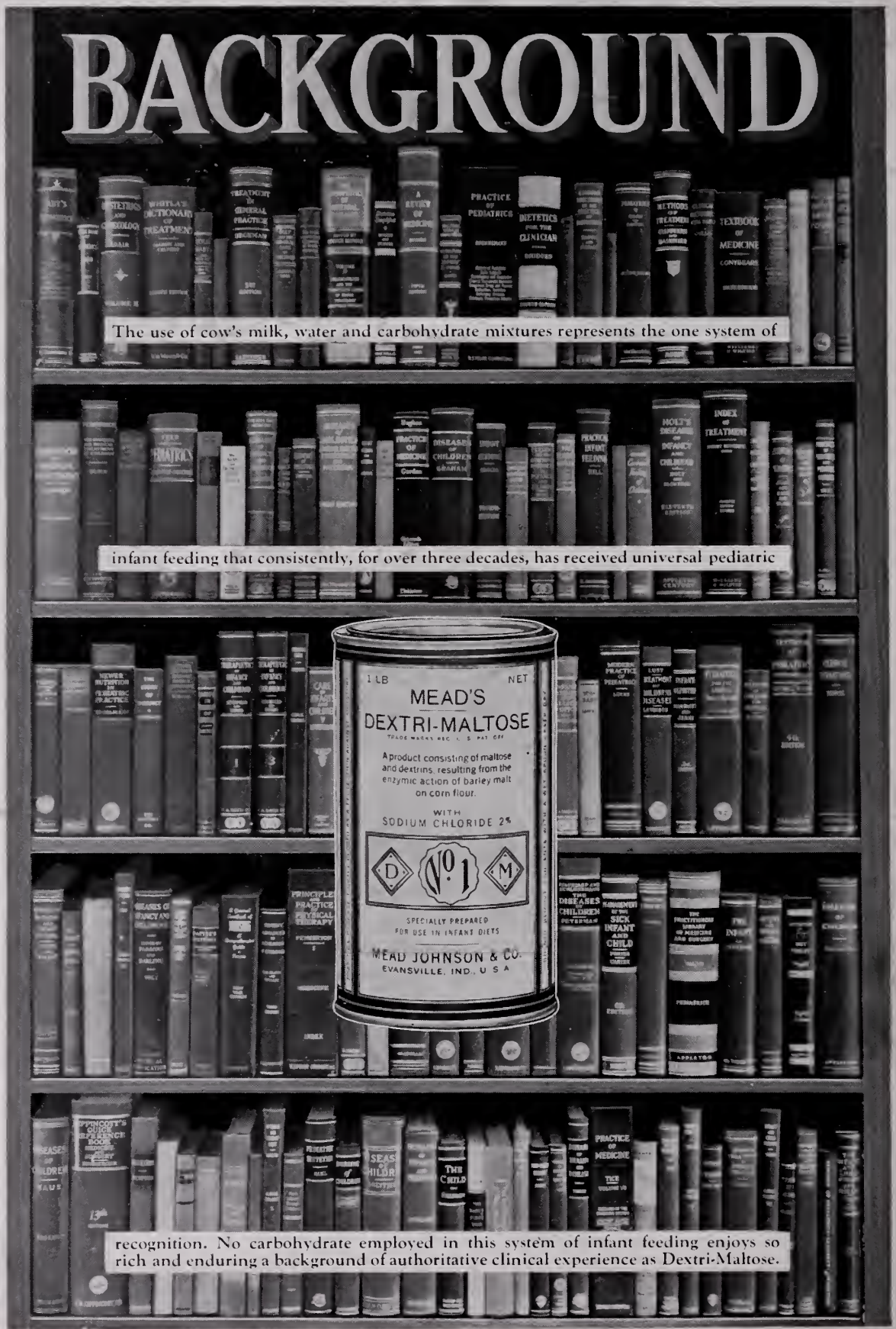


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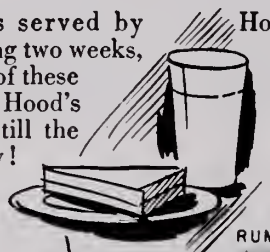
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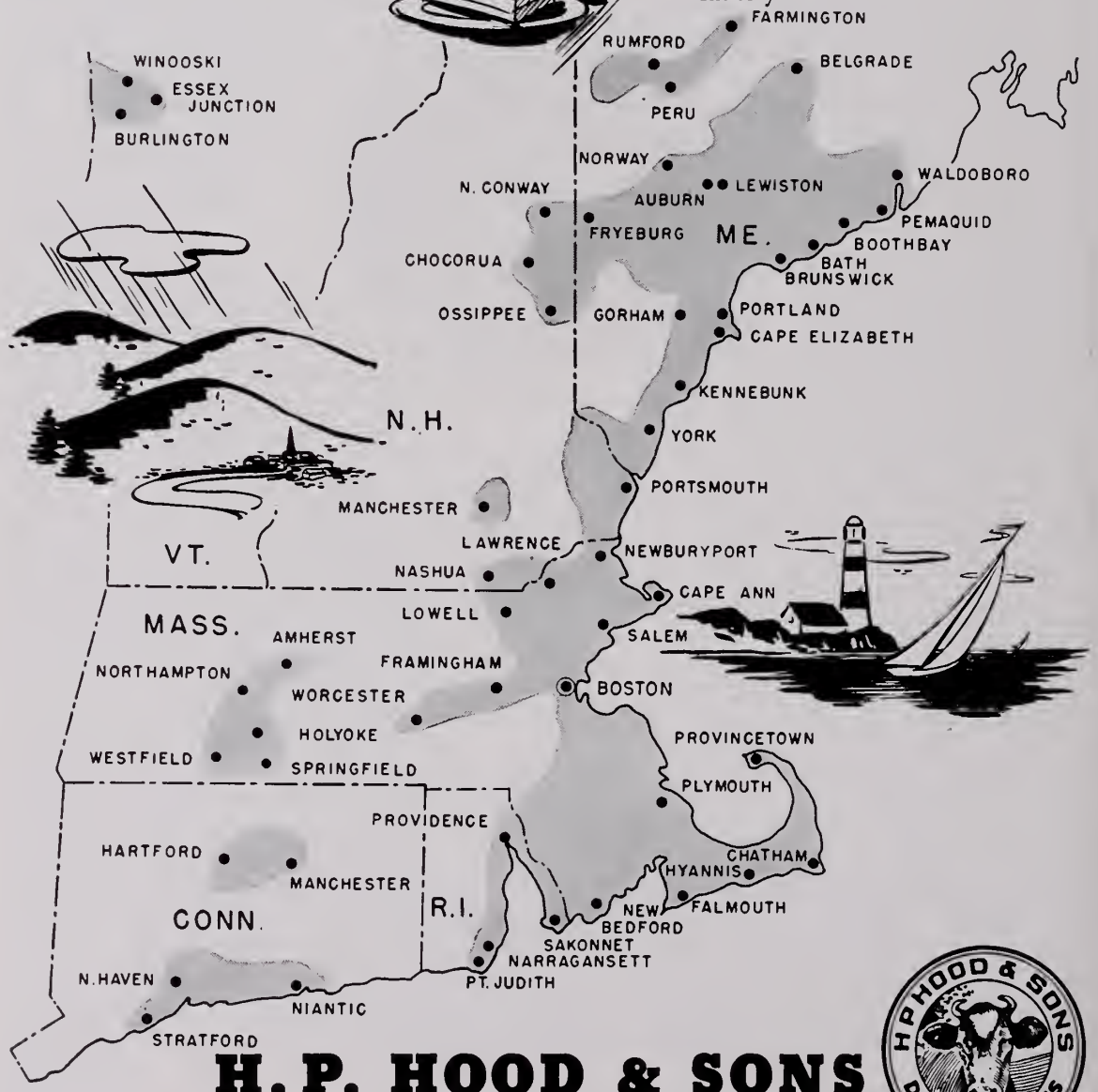
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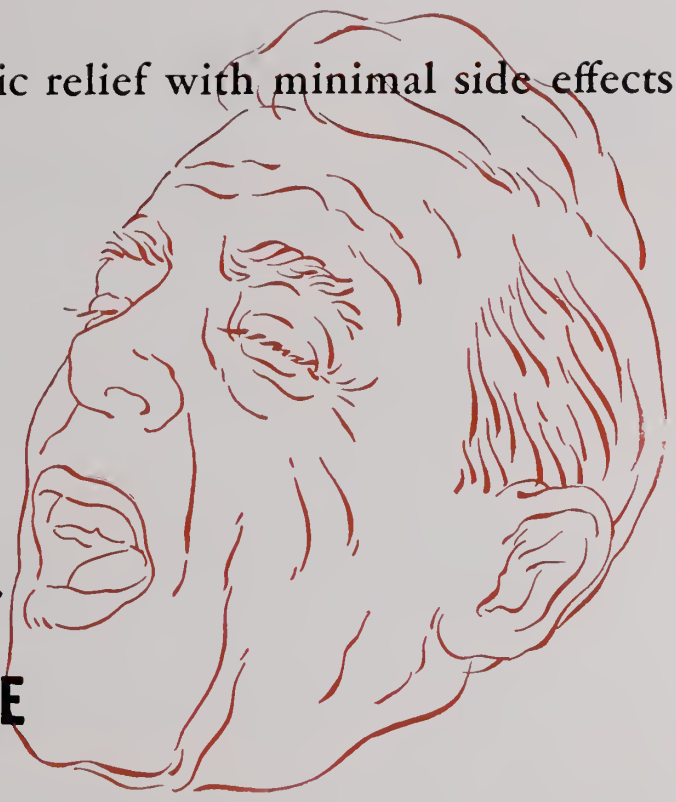


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1. Arbesman, C. E.: *N. Y. State Jl. of Med.*, 47: 1775, 1947.
2. Loveless, M. H.: *Am. Jl. of Med.*, 3: 296, 1947.
3. Bernstein, Rose and Feinberg: *Ill. Med. Jl.*, 92: 2, 1947.
4. Osborne, Jordon and Rausch: *Arch. of Derm. & Syph.*, 55: 318, 1947.

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MEAT

And the Dietary of Pregnancy and Lactation

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This study again emphasizes the need for a diet rich in biologically complete protein during the latter half of pregnancy. In this manner, the physiologic loss of nitrogen at term can be compensated, avoiding negative nitrogen balance. A high protein diet has the further advantage of producing a more copious milk supply.

In another recent publication,[2] the prevention of the toxemias of pregnancy by dietary means was stressed. Foremost among the measures recommended was a diet rich in high quality protein to assure nitrogen balance.

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[1] Stuart, H.C.: Effects of Protein Deficiency on the Pregnant Woman and Fetus and on the Infant and Child, New England J. Med. 236:507 (Apr. 3) 1947.

[2] Zeigler, R.F., Jr.: Pre-eclamptic Toxemia of Pregnancy. North Carolina M. J. 8:655 (Oct.) 1947.

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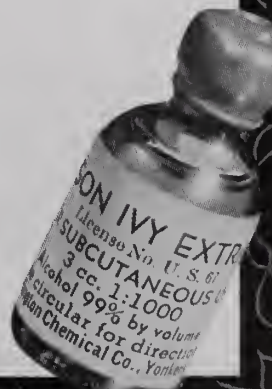
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TABLE OF CONTENTS

PAGE

Neurological Aspects of Poliomyelitis, *Henry R. Viets,* M.D. 427
The Challenge of Medicine in the Atomic Era, *Edward L. Bortz,* M.D. 430
A New Technique in the Radical Cure of Hydrocele, *Vincent J. Oddo,* M.D. 433
Fundamentals of Staff Organization, *Charles F. Wilkinson, Jr.,* M.D. 437

EDITORIALS

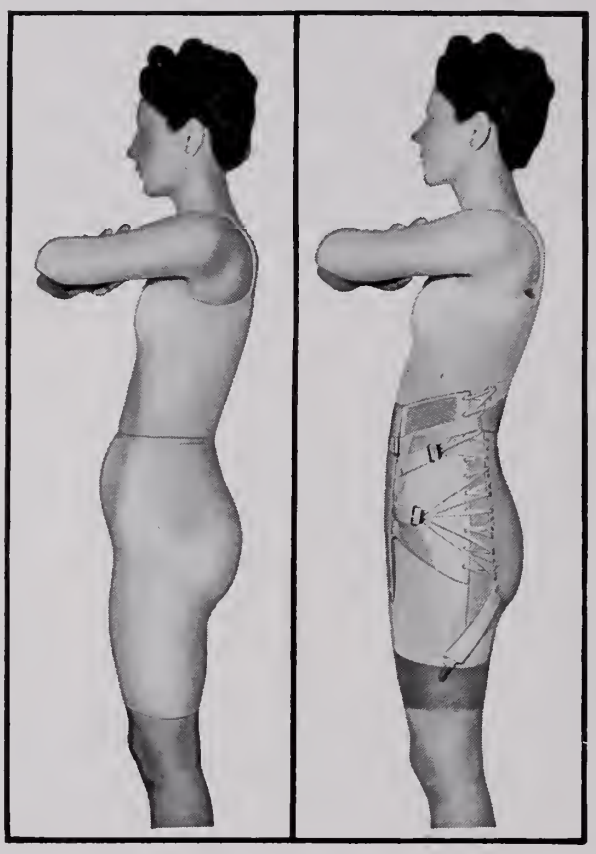
Treatment of Bulbar Poliomyelitis 439
Guy W. Wells, M.D. 440

DEPARTMENTS

Annual Dinner, R. I. Medical Society 444
Annual Reports, R. I. Medical Society 456
District Medical Society Meetings 452
General Session, R. I. Medical Society 442

MISCELLANEOUS

Additional Participating Physicians, R. I. Surgical Plan 448
Index of Advertisers 467
Photograph: Joseph C. O'Connell, M.D., Inducted as President 443



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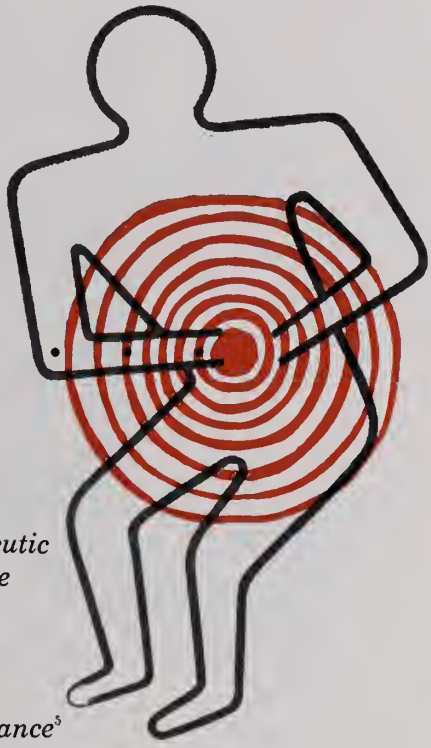
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[1] Malyoth, G.: Klin. Wchnschr. *13*:51, 1934.
[2] Bittner, J. E., Jr.: Northwest Med. *35*:445 (Dec.) 1936.
[3] Myers, P. B., and Rouse, A. H.: Am. J. Digest. Dis. *7*:39 (Jan.) 1940.
[4] Powers, J. L.: Bull. National Formulary Committee *9*:5 (Oct.) 1940.
[5] Block, L. H., Tarnowski, A., and Green, B. L.: Am. J. Digest. Dis. *6*:96 (Apr.) 1939.
[6] Morrison, L. M.: Am. J. Digest. Dis. *13*:196 (June) 1946.



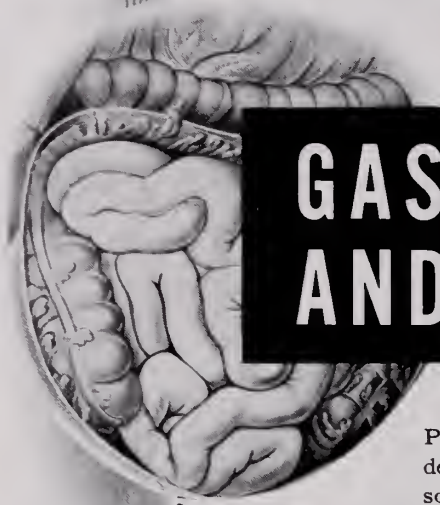
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1. Canada M. A. J. 54:283 (Mar.) 1946.
2. J. South Carolina M. A. 44:17 (Jan.) 1948.

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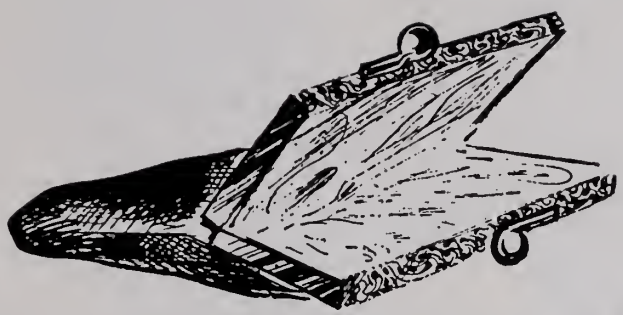


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MORE than any other Latin-American country, Argentina resembles the United States in climate, industries, and educational system. Although Argentina produces a large share of her own industrial and agricultural requirements, a mutually profitable trade has developed between the two countries.

The first Lilly medical service representative in Argentina began his calls on physicians and pharmacists in 1931. In 1944, Eli Lilly and Company of Argentina, Inc., was formed. Today, over 13,000 physicians are visited regularly. All medical literature, including the *Physician's Bulletin,* is printed in Spanish. Cordial relations of long standing exist between the men engaged in medical research and Eli Lilly and Company. The facilities of the Lilly Research Laboratories are always available for collaboration on mutually interesting projects. The beneficiaries of medical research are all peoples everywhere.



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NEUROLOGICAL ASPECTS OF POLIOMYELITIS*

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POLIOMYELITIS continues to be an ever present menace to the health of the citizens in the United States and indeed throughout the world. Great epidemics of this disease have swept this country in the last few years. In 1916 occurred the greatest epidemic of recent times but there was a marked upswing in the number of cases in 1943, 1944, 1945 and 1946. Indeed the epidemic of 1946 proved to be, with the exception of 1916, the largest this country had ever experienced with over 25,000 recorded cases.

In recent years there has been a high rate of bulbar poliomyelitis in many areas of the country. In the 1946 Minnesota epidemic, for instance, the incidence of bulbar involvement among the unselected cases of the disease in patients admitted to an emergency clinic was 23 percent in children under sixteen years of age and even higher in patients beyond this age.[1] Furthermore, of 1300 cases observed in 1943 to 1946, from Rockford and Cook County, Illinois, and Hickory, North Carolina, over a fifth were of the bulbar or bulbar-spinal type and the fatality rate in this group was 23.2 percent for the bulbar cases and 46 percent for the bulbar-spinal cases. In contrast, the spinal cases, about four-fifths of the total number, had a fatality rate of slightly over 1 percent.[2] The number of bulbar cases, therefore, formed a greater proportion of the whole than had previously been reported in poliomyelitis statistics and the fatality rate was almost uniformly high in each year from 1943 on. Newer forms of treatment, many of them inaugurated as recently as 1946, have resulted in a marked improvement in this rate, an important aspect of poliomyelitis that should be given consideration at this time.

* Presented before the Rhode Island Medical Society at Its 137th Annual Meeting, at Providence, May 13, 1948.

It should not be forgotten, however, that there are other large problems connected with poliomyelitis that deserve our full consideration: studies on epidemiology, other virus diseases, chemotherapy, transmission by direct contact, by excreta, by animals such as the fly, rodents and others, and finally the bio-chemical reactions of the nervous system that might be of use in creating a barrier against the invasion of the virus or its neutralization before it penetrates deeply into the vital tissues such as the anterior horn cells. Each of these aspects of the problem is being actively investigated at various clinics and research centers in this country. The National Foundation for Infantile Paralysis gives financial assistance to many of these centers and acts as a stimulating agent for research throughout the country.[3] This great effort, combined with other stimuli of a similar nature, gradually is encompassing the problem of the cause and transmission of poliomyelitis. Until the cause of poliomyelitis is found and means for its elimination made available, the principal activity against the disease from the physician's viewpoint must be in the therapeutic field and the emergency care of the patient with bulbar poliomyelitis becomes a matter of primary importance.

Bulbar Poliomyelitis

Bulbar poliomyelitis is now considered as a disease primarily affecting the whole of the brain stem, including the medulla, pons and midbrain. Four symptom complexes are now recognized for the purposes of classification and for more adequate treatment of the emergency case. Each of the clinical groups presents special problems, both in diagnosis and in treatment and it is necessary to visualize them in order to handle a case of bulbar poliomyelitis efficiently. Primarily diagnosis is in the hands of a general practitioner who usually is the first to see a patient with signs of poliomyelitis. The patient with the spinal form of the disease, with paralysis of the arms and legs, usually presents no problem in diagnosis once the

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paralysis has disclosed itself. The clue to bulbar poliomyelitis is found in (1) the involvement of the nuclei of the cranial nerves with resulting paralysis of the muscles supplied by them, (2) in a disturbance of the respiratory or circulatory centers in the brain stem, or finally, (3) in the mental symptoms due to encephalitis, an unusual manifestation of this disease.

(1) *Cranial nerve paralysis.* Any of the motor nuclei of the cranial nerves may be affected in poliomyelitis. These consist of the third, fourth and sixth cranial nerves supplying the muscles which move the eye; the motor component of the fifth cranial nerve supplying the masseter and pterygoid muscles; the seventh cranial nerve supplying the muscles of expression of the face; the ninth supplying the pharynx; the tenth which supplies both the pharynx and the larynx; the eleventh supplying the trapezius and sterno-mastoid muscles in the shoulders and neck; and the twelfth supplying the tongue. All except the tenth give rise to the symptom of relatively minor significance. None cause death in the acute stage of poliomyelitis, although pharyngeal paralysis may be a contributing cause. It is only when the tenth cranial nerve is involved, with resulting dysphagia and dysarthria that life is primarily endangered. Thus the importance of the paralysis of muscles supplied by cranial nerves other than the tenth lies in their value as indicators of disease in the brain stem rather than as signals of impending disaster. Weakness of the eye muscles, the masseters, the facials, the shoulder and tongue may occur without calling for immediate emergency treatment.

The observation, however, of weakness in a single muscle supplied by any cranial nerve should immediately bring to the physician's mind the potential gravity of the patient's illness and hospitalization should be carried out without fail. For transportation an ambulance is needed. Postural drainage of saliva of the mouth is one of the most important aspects of immediate treatment and patients should never be sent to the hospital sitting up. In addition, suction apparatus or a rubber suction syringe should be made available to aspirate the mucus out of the mouth if necessary. Transportation of patients over long distances cannot be recommended and excessive speed with the use of the siren may only excite a patient and make him worse. As Piszczek points out, "the smoothest, slowest ride to the hospital should be used. The patient should not be subjected to any strain or agitation and the patient's morale should be maintained at all times."[2]

When the hospital is reached, a long history of the case is not of importance and only enough examination should be made to make a satisfactory diagnosis. Usually the presence of fever, a rapid pulse, a nasal voice, inability to swallow, inability to cough or expectorate, facial paralysis or marked excitement or prostration, are signs of sufficient magnitude to make the diagnosis almost certain. Spinal puncture at this stage should be avoided as it is only likely to aggravate the condition. Patients should be placed in a special bed with solid boards and a hard mattress to give firm support. The foot of the bed should be elevated 15 to 20 degrees.

Tracheotomy. The most important decision to be made immediately is in regard to tracheotomy. If the patient is having a continuous problem in eliminating saliva and bronchial secretions, a tracheotomy should be seriously considered. The maintaining of an unobstructed airway is of first importance; if this cannot be done by postural drainage and aspiration, tracheotomy must be carried out.

The Minnesota Poliomyelitis Research Commission,[4] a group of physicians who handled 183 patients with bulbar poliomyelitis in the 1946 Minnesota epidemic, present the following criteria which they utilized in a decision on elective tracheotomy in bulbar poliomyelitis: recent onset of bulbar symptoms with evidence of progression of the illness during the period of observation; general appearance of toxicity, especially with high temperature and rapid pulse; progressive difficulties in swallowing or the accumulation of secretions in the throat; and mental changes, especially anxiety, apprehension, hyperactivity, confusion or euphoria in a patient with difficulty in swallowing. The decision, however, is not an easy one and the brilliant results of tracheotomy will be not infrequently offset by total failure. The criteria, however, are sufficiently clear so that this life-saving measure should be carried out promptly.

After tracheotomy, the patient with bulbar poliomyelitis requires expert care and special nurses are needed. It is necessary to continue the aspiration of the accumulation of fluids in the pharynx and the tracheal canula must be inspected and cleared frequently. If the tracheal secretions become viscid, an attempt may be made to humidify the inspirated air. The most successful method is to deliver moist air and oxygen mixtures directly into the tracheal tube by a tracheotomy inhalator, a method devised by the Minneapolis group.[5]

Under the general form of treatment outlined above, one hundred patients treated at Minneapolis in 1946, with symptoms limited to the cranial nerves, only five deaths occurred, four of these having taken place before an airway could be secured. The fifth death occurred from aspirated vomitus occluding the tracheotomy and thus all five deaths resulted directly from obstruction of

the airway. The reduction of deaths in this group to below five percent is perhaps the outstanding therapeutic advance in poliomyelitis in recent times and it is based on sound physiologic principles applied to patients with infection by poliomyelitis of the brain stem. Such a result would be impossible prior to the organization of skilled teams for the care of patients with this type of illness, the admission of patients to the general hospitals in the acute stage of the disease, an essential step in the success of the present-day therapy, the availability of special nursing care and the full recognition of the importance of hospitalization by the general practitioner as soon as signs of cranial nerve paralyses become evident.

(2) *Respiratory and circulatory paralysis.* In addition to involvement of the cranial nerve nuclei in patients with bulbar poliomyelitis, there is still a further group of patients who show respiratory distress based, not upon paralysis of the diaphragm or intercostal muscles supplied by anterior horn cells lying in the cervical and thoracic portions of the spinal cord, but on a central respiratory mechanism controlled by a vaguely outlined center in the medulla. Most of the patients in this group have cranial nerve involvement also. In spite of an adequate airway and with normal or only slightly affected respiratory musculature from spinal centers, in examples of central respiratory paralysis there will be a variation in the rate and depth of respirations with prolonged intervals between inspiration. In addition, patients with this type of bulbar poliomyelitis show anxiety, restlessness, an increasing pulse rate and sometimes an elevation of blood pressure, symptoms attributable to lack of oxygen, although cyanosis is not observed. When failure of the central respiratory system is disclosed, oxygen therapy should be started or increased if already in use. In a patient limited to this type of disorder, the mortality should be considerably lessened by the adequate use of oxygen. Unfortunately, most of the patients with disorders of the respiratory center in the medulla also have various cranial nerve involvements, particularly the tenth nerve for which they need a tracheotomy or cervical and thoracic spinal poliomyelitis requiring the use of a respirator. When all three are present at the same time, the chances of saving a life are indeed small and of the 36 cases classified clinically as belonging to the respiratory-circulatory group in the 1946 Minnesota epidemic, the mortality was nearly 70 percent.

Another group of patients show disorder of circulation as one of the primary signs of bulbar poliomyelitis. Only twelve out of 183 bulbar cases were so classified in the Minneapolis epidemic. The mortality was over 80 percent. The patients showed a dusky red, florid appearance. The pulse rate was out of proportion to the temperature and ranged as high as 150 to 200; the rhythm was often irregular. Great anxiety and restlessness was always present. Prior to circulatory failure blood pressures dropped to shock levels and the patients expired in delirium, coma or terminal hyperthermia. If the symptoms were at all severe, treatment in this group was unsatisfactory.

(3) *Encephalitic group.* Finally, there are a few patients who develop encephalitic symptoms. The principal indications are anxiety, restlessness and hyper-excitability, muscular tremors and twitchings, irritability and confusion, lethargy, coma and convulsions. When these symptoms first appear, they may be considered as due to lack of oxygen or an unrecognized partial obstruction of the airway. When the airway is clear and adequate oxygen is being received some patients however will show signs of cortical irritation. The group is a small one, the mortality is low and although the symptoms appear alarming, they are of less importance than those produced by collapse of the respiratory or circulatory centers or by paralysis of the muscles supplied by the tenth cranial nerve.

Bulbar and Spinal Poliomyelitis Combined

When patients with bulbar poliomyelitis have in addition symptoms due to spinal involvement, respirator treatment may be required. Special types of respirators have been developed that will allow tracheotomy to be performed while the patient is still being maintained in the respirator. On the severity of the paralysis of the diaphragm and intercostal muscles, often depends the outcome. The prognosis of the combined cases, however, is very grave. Few adults survive; children tend to do better.

Summary

1. Bulbar poliomyelitis has shown a high rate of incidence in epidemics of this disease since 1943. In statistics from various parts of the country about 20 percent of all cases had bulbar symptoms.

2. The fatality rate until recent times was above 20 percent for bulbar cases and over 40 percent for bulbar-spinal cases.

3. In the Minnesota epidemic of 1946, the mortality rate was reduced to five percent.

4. Rapid diagnosis, intelligent transportation to hospitals, the use of general hospitals, teams of physicians and nurses, tracheotomy, oxygen, adequate drainage and the use of the respirator were factors in the favorable fatality rate.

5. No community is immune to poliomyelitis. All should be "alerted" if the fatality rate of bulbar

continued on page 450

THE CHALLENGE OF MEDICINE IN THE ATOMIC ERA*

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IT IS a high privilege and honor to be your guest on the occasion of the One Hundred and Thirty-Seventh Annual meeting of the Rhode Island Medical Society. The medical profession in this beautiful New England setting is rich in tradition and large in accomplishments. You are regarded as one of the progressive and far-visioned Societies of our great land. Your Scientific Program at this Meeting is filled with discussions of topics of major importance, and your speakers are recognized authorities.

Medicine Today

It is my purpose this evening to consider with you the status of medicine today and survey a few of the trends appearing in the work of our profession.

The expanding frontiers of medical science have yielded insight into the nature of many of the disorders and diseases which beset mankind. Even before the war, use of the scientific method and well integrated programs in the various fields furnished new information about various kinds of infections, nutritional disturbances, glandular conditions, cancer, and the degenerative processes of the body. Military necessity mobilized scientific talent in particular directions that greatly accelerated the speed of discovery. For example, fractionation of the blood as developed by Cohn of Harvard, and the greatly augmented use of plasma and blood substitutes served to reduce the mortality rate of wartime casualties. While the development in the field of infectious diseases was well on the way before the war, the improvement in methods which took place during the war and afterward are preserving lives which earlier would have been snuffed out rather promptly.

Knowledge in the field of nutrition, with reference to the usefulness of the various vitamins, has opened new fields of investigation. We now possess a fund of information of lasting value about the specific nutritional needs of the body. Discoveries which have revealed the chemical nature of the steroids, and the close relationship chemically of substances which are important in the glandular activities of the body, have opened new fields of scientific inquiry. Indeed the world of medicine has derived rich benefits from the application of science in the realm of disease control.

The atomic age now starts a new chapter in man's study of man and his infirmities. With the increasingly effective control of those disorders which in earlier years had exacted a high mortality rate, science may focus its abilities on fields that up to the present have not been explored. With life-saving measures which have reduced maternal and infant mortality and protected youth from the ravages which earlier were so destructive, a larger percentage of the population is growing into years in which the degeneration of body tissues commonly takes place While cancer, too, is likely to appear in any group, it is most common in the mature periods of life.

Atomic Elements of Medical Importance

While the attention of the public is daily being confronted with reports concerning the military applications of atomic power, the utilization of radioactive isotopes is blazing new trails in the realm of biology Even the vocabulary of medicine is being changed with such rapidity that one finds difficulty in keeping abreast of medical activities. This is a healthy sign, and a stimulating challenge to medicine as a learned profession. Einstein has stated that "The atomic era makes it necessary for us now to think in new terms." This statement has an especial application for medicine. It may well be that the benefits from the intelligent and humanitarian application of atomic power will become so attractive to all people that its use as a force for human destruction may sink into oblivion. With the use of the magic bullets — the isotopes — concerning which every physician should inform himself, our understanding of the physiological processes of the human body may be greatly expanded. Also, with these new elements, a better

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conception of the early deviations from normal growth, at which point in cellular activity within the body a cancerous tendency is initiated, may be more readily identified. Premature tissue deterioration is a subject of immense importance to the medical profession since many people are becoming victims of this condition as they grow into the mature years.

The earliest lesions of atheromatosis now appear to result from a disturbance in the intermediary fat metabolism of the body. For example, it can be proven experimentally by feeding animals large quantities of fat that fatty degeneration beneath the lining of blood vessels commonly occurs. At present we do not know exactly how this takes place, although there are certain attractive hypotheses which have been offered to explain the deposition. With the introduction of tagged atoms into fat molecules, more information should be gleaned of the little understood intermediary steps which lead to the precipitation of fat within the walls of blood vessels. This represents the first lesion, so far as we know today, of deterioration in the vascular system. The magic bullets should give medicine a new weapon to combat the common disease of arteriosclerosis. And here let me emphasize again the fact that growing old of itself is not a disease. There are many older folks whose blood vessel systems are comparatively free from the degenerative lesions of the vascular system. Arteriosclerosis is not an essential accompaniment of ageing. It can be prevented experimentally in lower animals by the marked restriction in the fat intake in the body. Researches in the field of vascular disorders are of vital importance to our nation since lesions of the blood vessels destroy more than 600,000 lives a year. Circulatory diseases killed four times as many people as were destroyed by cancer in 1947. It is high time that a greater percentage of the funds expended in the fields of medical research be directed into channels which are probing for the secrets of tissue degeneration.

Curiously, the more we learn about tissue degeneration and tissue repair, the more we will learn about the fundamental nature of cancer because normal growth and normal tissue repair are governed by the phyiological laws of living cells. In this realm should ultimately be found the basic nature of the abnormality which becomes the cancerous growth.

It is my belief that, during the next quarter century, science will extend the boundaries of our knowledge and understanding of the basic natural laws which govern the psychological processes necessary to human existence. As we learn more about intermediary metabolism, refined methods for control of these distortions and deflections from the normal will appear.

It is safe to conclude that the atomic era offers rich promise for wider understanding of the physical maladies of the human body. When the major destructive processes which now are responsible for the loss of three-quarters of a million lives each year are brought under control, a further substantial increase in the life span will become evident.

Problems of Personality

Diseases of man's physical body are yielding to improved methods of management. But man is more than a physical mechanism, a transformer of energy. It is a curious fact that, at a time when our control of infections, our understanding of glandular and nutritional disorders, and our insight into other problems of the physical body have brought us remarkable control over these diseases, some fifty-seven percent of hospital beds in our nation are taken up by patients with psychiatric and nervous disturbances.

Someone has said that the higher the civilization, the longer the shadow it casts. Man's inability to adjust himself in the face of industrial and material progress has placed a great strain on large numbers of our fellow citizens. Nevertheless, substantial progress has been made in our understanding of mental disorders, and I believe that science will ultimately find better methods for the identification of incipient deviations from the normal. Then more adequate measures for prevention, control and repair may be predicted.

New Frontiers

The distinguished Roger J. Williams some time ago stated, "We are in the ox-cart days, so far as the utilization of human resources is concerned." And the beloved Walter B. Cannon whom you all knew many years ago, introduced new methods of investigation which dealt with rage, fear, and the competitive instincts of animals. He stressed the need for a wider and, at the same time, a more concentrated approach to the study of emotional problems. Here is one of the important new frontiers. For are not men creatures of moods and fancies, hopes, fears and aspirations?

In the new era, science has come upon astounding sources of energy which, if correctly harnessed, may furnish all the nations of the world with sufficient power to carry on their industrial productive programs with no hint of serious depletion. And medical science is extending the span of life and adding more health to the later years, especially in communities and nations where modern methods

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of disease control and prevention of disease-spread is in common usage. In this new day, because of man's inability to understand himself and his fellow man, and to fashion a social program that will offer each individual optimum opportunity for self- and social-development, an ominous darkness threatens to engulf humanity.

It was Descartes, I believe, who made the statement "If ever mankind is to develop and grow materially, culturally and spiritually, medical science will perform that service." Now that success has crowned the efforts of science to control the denizons of the microcosm, that is the inhabitants of the bacterial world, we need to direct our attention more and more to logical procedures that will give us equally clear visions of the emotional and social problems which are causing such a vast amount of unhappiness in the world.

Social Medicine

Organized medicine has three major objectives, namely, medical education of a continuing high order; education of the public, and extension of the benefits of modern medical science to all the people of our land, and third, medical research.

In the field of medical education, some pressure has been brought to bear to have medical schools increase their output of graduates. Statements have appeared on the shortage of physicians. It must be admitted that there is a maldistribution. But within the next five to eight years some twenty thousand young medical graduates now in process of intern and residency training will be seeking positions and areas where they may establish themselves in practice. Basically, as a nation, we should have, not more physicians, but fewer patients. As the medical profession conducts an educational program stressing prevention and the maintenance of a high level of health education which should be taught in all schools, morbidity rates will show some decline.

The problems of the distribution of medical service are now under critical scrutiny. The Bureau of Medical Economic Research with its capable director, Frank D. Dickinson, Ph.D., is performing an excellent service to the nation by charting medical service areas in several of the states In this study now going on, medical needs of each community in these states are being plotted against the supply of professional personnel available. Therefore, for the first time, a basically unemotional, strictly factual study of the medical needs of the people is being conducted by a Director whose corps of able assistants are in search of the truth, with no aim to support any particular point of view.

Medicine is a social profession. The daily routine of each physician is a contribution to the social welfare of his community. The medical literature now is again replete with considerable discussion of the social phases and psychosomatic problems. Yet there is nothing essentially new or unique about this development. The philosophers centuries ago weighed the influences of heredity, environment and the influences of social mores on community life.

The Challenge to Medicine

The medical man is particularly fitted by instinct, training and experience to evaluate the influence of the social atmosphere on the welfare of patients. However, physicians too often fail to accept their full responsibility as citizens. As a profession, we are willing to forfeit the conduct of civic affairs not infrequently to vocal representatives of pressure groups bent on preferential consideration for powerful political minorities. In this circumstance, society finds the root of the social cancer which, when uncontrolled, has overthrown democratic peoples and shackled other nations with a form of government inimicable to the best interests of their homeland.

Medicine as a humanitarian profession must awaken to the importance of its great social obligations. The medical profession is dedicated to the support and protection of human life and the elevation of the human intellect, to the preservation of individual freedom. These objectives offer the greater opportunity for the flowering of the human spirit. Our profession must join with other humanitarian groups to combat the forces of a government which threatens to enslave mankind.

We are opening a most exciting new chapter in world history. Never has medical science — never has the practicing physician had the opportunity to render such superb personal and social service to his community. As a profession, we need to be stirred to greater action and play a larger role. Important problems are before the American people. Our fitness as a nation to survive will depend on the understanding with which we as a people solve these problems. Our destiny as a nation depends on the program which we must develop that will bring encouragement and hope and a new interest in living for the stricken people of the world. May we rise to our full power and help to guide the destiny of man in the atomic era to a better day for our fellow men. Medicine has a dominant role to play. Let us be on our way.

A NEW TECHNIQUE IN THE RADICAL CURE OF HYDROCELE*

VINCENT J. ODDO, M.D., F.A.C.S.

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MANY FORMS of treatment have been advocated for the cure of hydrocele. Tapping of the hydrocele, or tapping with the injection of a sclerosing solution into the tunica vaginalis sac, have a large number of adherents. There is no doubt, that in some cases excellent results have been obtained by these procedures, but it is equally true, as statistics indicate, that a certain number require repeated tappings and injections.

However, at the present time, the majority of surgeons prefer the open operation. Different techniques have been proposed for the repair of hydrocele simply because no single method has proved entirely satisfactory.

Winkelmann advised only partial excision of the sac, eversion of the proximal portion of this sac, and suturing the edges posterior to the epididymis. In this operation, great care must be exercised to prevent hemorrhage and resulting hematoma.

Andrews 'bottle operation', consists of opening the tunica vaginalis sac, turning it inside out, and suturing it behind the epididymis. It is a simple procedure and probably the most commonly used. Its disadvantages, however, are that it leaves a large mass of tissue behind the testicle, there may be occasional recurrences, and frequent and extensive hematomas. So in these cases, meticulous care needs to be used in the clamping and ligation of all bleeding vessels.

In the Van Bergmann technique, all of the parietal layer of the tunica vaginalis is excised.

Volkmann, after incising the tunica vaginalis and suturing the edges to the scrotal skin, wipes the cavity with carbolic acid and then packs it with gauze. The sac is then allowed to heal by granulation.

Klapp, instead, substitutes the reefing of the tunica vaginalis for the eversion.

In 1940, Hugh H. Young, described a new technique for the radical cure of hydrocele, by excision of the serous layer of the tunica vaginalis. Several cases were reported with uniformly good results.

Croot described an operation in 1944, in which, after the tunica vaginalis is everted and the dartos and skin approximated, the scrotum is anchored to the abdomen. He states that with this method, the post-operative swelling of the scrotum is eliminated.

The purpose in all of these techniques is either to excise the tunica vaginalis or attempt to obliterate the endothelial lining of the tunic.

Several years ago, the author felt that the operation for the radical cure of hydrocele could be very much simplified by utilizing a new physiological principle. It has always appeared to me that a hydrocele formed because of an injury to the endothelial cells of the tunica vaginalis, with a consequent outpouring of an effusion. This injury could be ascribed to trauma or to an infective process. *(Plates 1-2-3)*

PLATE 1



Low power—showing a cross section of the tunica vaginalis, in a patient, aged 52 years, who suffered two years with a hydrocele.

(a) Enlarged endothelial cells.

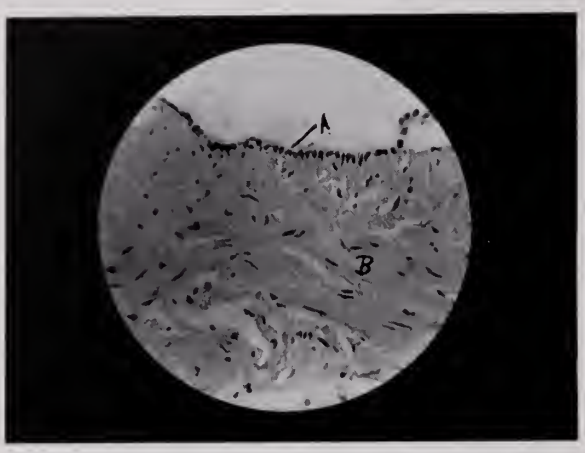
(b) Increase in fibrous tissue.

(c) Artery, showing leucocytic infiltration.

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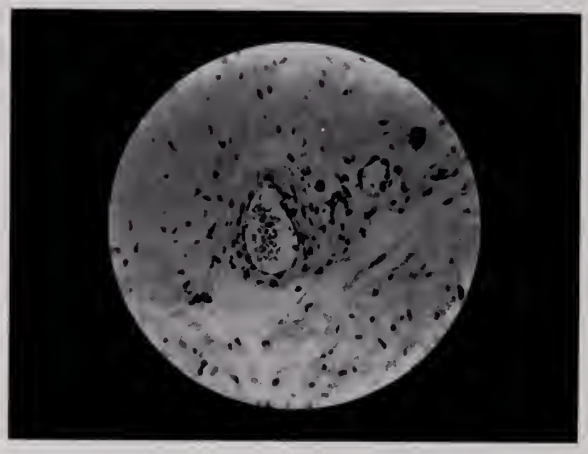
* *Presented before the Providence Medical Association, at Providence, April 5, 1948.*

PLATE 2



High power—The endothelial cells (a) are hyperactive; they are very large and swollen, cuboidal to columnar in shape; nuclei are very prominent. There is an increase in fibrous tissue (b) beneath the endothelial lining.

PLATE 3



High power—Demonstrating an artery with perivascular leucocytic infiltration.
All of these changes in the tunica vaginalis are consistent with a mild chronic inflammatory process.

During the past three years, the following technique has been followed in eighteen cases. The smallest sac contained one ounce of fluid, the largest thirty-six ounces. There were neither recurrences, nor complications of hemorrhage or hematoma. There was one death, in an elderly patient, aged seventy-nine years, from coronary embolism.

The drawings by William P. Didusch very graphically depict the various steps of the operation, and therefore, little descriptive text is necessary. *(Plate 4) (Figures 1-5)*

As shown in figure I the sac is grasped and put on tension. An incision beginning at the lower and extending to the upper end, was made thru the skin, subcutaneous fascia and dartos, down to the tunica vaginalis. The tunic is now freely separated from the dartos in a circular manner for a distance of about one inch.

In figure 2 the tunic is opened, the testis and epididymis are examined.

In figure 3 the edges of the tunic are everted about one quarter of an inch, and sutured to the external layer of the tunic with interrupted plain catgut. Thus a permanent opening is made in the tunic, the lining of which is made up of endothelial cells. This aperture cannot become occluded because the raw edges of the tunic have been everted.

In figure 4 a section of the scrotum is shown.

In figure 5 a rubber drain is placed into the sac, the dartos is closed with chromic catgut, and the skin with silk.

The scrotum is then enclosed within a gauze pad, and an adhesive bandage applied tightly. The drain is removed in twenty-four hours, and the skin sutures in three or four days. The patient is advised to wear a suspensory bandage for a while.

EXCERPTS FROM CLINICAL NOTES OF SEVERAL CASES

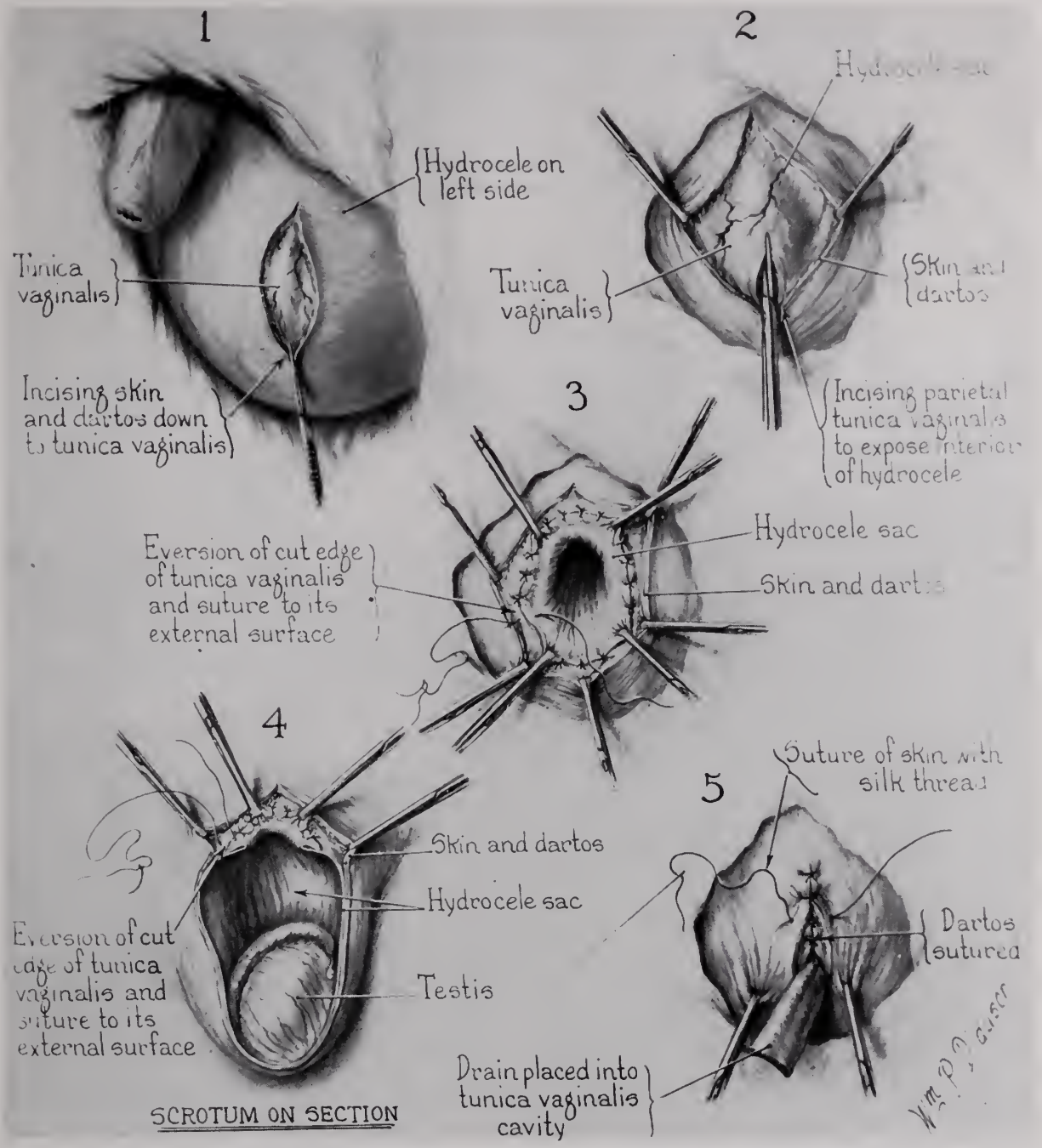
CASE I—The Patient complained of an ache in the right scrotum. A hydrocele of medium size, containing three ounces of clear, straw colored fluid were found. A smaller hydrocele was present on the left side, which did not cause any symptoms. In this case an aperture was made in the tunica vaginalis on each side.

CASE 2—This patient, aged 74 years, developed a right hydrocele after a fall down stairs twenty years previously. He complained of a sensation of weight in the right scrotum. Six ounces of fluid, clear and straw colored were removed. An aperture in the tunica vaginalis was made. The patient was seen recently and the tunic contained no fluid.

CASE 3—This case complained of pain and a sense of weight in the right scrotum. At operation, sixteen ounces of clear straw colored fluid were removed. An aperture was made in the tunica vaginalis. The swelling in this case did not subside for one month. However, now there is no fluid present.

CASE 4—This little boy, aged three years, had a swelling of the left scrotum. The mother was alarmed and desired immediate treatment for her son. Six months ago, the boy fell from a chair, and the swelling in the scrotum was found soon afterwards. At operation, one ounce of clear straw colored fluid was removed. An aperture was made in the tunica vaginalis.

PLATE 4



Showing the method in the new technique for the radical cure of hydrocele.

CASE 5—The scrotum in this elderly patient, aged 65 years, was tapped six months previously; and since that time, the swelling became greater and more painful. The scrotum could not be transilluminated. At operation, two ounces of bloody fluid were obtained. This was probably the result of the tapping. The inner surface of the tunica was pale, and roughened; the parietal and visceral layer of the tunica vaginalis were much thickened. The testis was atrophic. Castration was performed. The biopsy showed that the testis was still active and healthy. This testis could have been saved by making an aperture in the tunica vaginalis.

CASE 6—In this patient, aged 45 years, there was a complaint of an ache in the left scrotum. Two and one-half ounces of clear straw colored

continued on next page

fluid were obtained. An aperture was made in the tunica vaginalis, no drain was inserted, and the dartos and skin closed tightly. This was done purposely to see whether the hydrocele would recur. Since the operation, seven months ago, no fluid has formed in the tunic.

CASE 7—The right scrotum in this fifty-five year old individual was fairly big, caused a great deal of pain and a sense of weight. It contained twenty-five ounces of clear straw colored fluid. An aperture was made in the tunica vaginalis. The scrotum healed rapidly. Since the operation two years ago, the patient has been comfortable.

CASE 8—This elderly male, aged 79 years, was rushed to the hospital because of acute urinary retention from an enlarged benign prostate. A cystotomy was performed under spinal anesthesia. The patient also suffered from a large hydrocele on the right side for the past twenty-five years. Seven days following the first operation, the hydrocele was repaired by making an aperture in the tunica vaginalis. Thirty-six ounces of fluid were obtained. On examining the testis, a hydrocele containing three ounces of clear colored fluid was found behind the globus major. This was opened and an aperture made in the same way as in the outer tunic. The patient progressed well for three days, when he suddenly developed coronary embolism and expired. The scrotum was dressed on the third day and there was no swelling.

CASE 9—This very obese patient, aged 52 years, developed a swelling of the left scrotum soon after lifting a heavy pail, about two years previously. A sense of weight disturbed the patient. At operation, two ounces of clear straw colored fluid was removed. An aperture was made in the tunica. No drain was used. The dartos and skin were closed tightly. He was discharged on the fourth post operative day. There was very little swelling in the scrotum.

SUMMARY

It has not seemed practical to me to excise or evert the tunica vaginalis behind the testis, since in most instances, the lining of the tunica appeared healthy on inspection. It was with this idea in mind that the author has devised and presented this operation. While it is true that this technique has been done on a small number of cases, it still deserves consideration by the medical profession.

With this technique, which could be called the formation of a window in the tunica vaginalis, the anatomical relationships of the tunica and testis are not disturbed, the testis is still surrounded by a small amount of serous fluid, and does not become adherent to the surrounding tissues, as in all other operations. While the purpose of other methods of treatment has been to excise or obliterate the endothelial lining, with this new technique, the aim is to preserve and protect the endothelial cells of the tunica vaginalis. In the operative procedure, the edges of the opened tunica vaginalis are everted, producing a permanent aperture lined by endothelial cells. The fluid which is formed subsequently, is absorbed by the capillaries and lymphatics of the dartos, until the cells of the tunica vaginalis resume their normal physiological function.

Cases number six and nine, for example, in which the dartos and skin were closed tightly without drainage, demonstrate the absorbent powers of the dartos. It is felt, that, once the continuous pressure in the tunica is removed, the chronic inflammatory process subsides, with no further outpouring of an effusion.

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FUNDAMENTALS OF STAFF ORGANIZATION*

CHARLES F. WILKINSON, JR., M.D.

The Author. *Charles F. Wilkinson, M.D., of Ann Arbor, Michigan. Coordinator of Graduate Medical Education, University of Michigan, Ann Arbor.*

IN ORGANIZING a staff for a hospital, a great deal will depend on the size of the hospital, whether it is connected with a University, affiliated with the University, or strictly independent of University connections. It will also depend on whether the staff is full-time at the hospital or if the majority of the staff are employed in full-time practice.

Let us consider first, the hospital of 100-150 beds which is staffed by practicing physicians whose primary interest is in their private practice rather than in teaching medicine. Here, the staff organization will be relatively loose and the staff will be quite large. The chief of staff and heads of the various services may change from year to year and such a position may be awarded to an older man in recognition of service rendered to the hospital and the community. Such a man may not have the time to devote to teaching nor may he have the inclination. In a staff such as this, it is wise to have an educational committee composed of younger members who are interested in teaching the intern and resident staff and who have the enthusiasm and the time to devote to this. This educational committee should be responsible jointly to the chief of staff and to the chief resident physician or hospital administrator so that there will be no conflict between routine duties of the resident staff and the time allotted for their instruction. It should outline broad programs which will then be implemented by the chief of service whose responsibility it is to see that individuals are available for different teaching assignments.

The problem is more simple in a university hospital where it is assumed that a large number of the men are full-time. Here, we have a group who are devoting their lives to teaching and it is to be assumed that a teaching schedule will be worked out in close connection with that of the medical students, so that all the facilities of the university are available to the resident staff.

*Presented at the Third New England Institute for Hospital Administrators, at Brown University, Providence, on June 25, 1947.

Here again, however, there must be close cooperation between the administrative branch and the professional branch of the hospital so that neither group will feel that it is being deprived of its just share of the resident staff's time.

In a third intermediary group of hospitals, we will find hospitals that are not university hospitals, but affiliated with a university. This group may expect varying degrees of cooperation to aid in their teaching program.

In many of the above-mentioned types of hospitals, the professional and administrative staff will parallel each other, but should have closer liaison so that the functions of the hospital—(1) care for the sick, (2) to continue the physician's education, and (3) research—may be carried out.

Elements for Ideal Practice

At this point, it might be well for me to emphasize the fact that the ideal practice of medicine is made up of these elements: namely, (1) The care of the sick; (2) The teaching of the art and science of medicine; and (3) Research in either the basic medical sciences or clinical investigation. We must not consider a hospital as an institution where only diagnoses are made, operations performed, and drugs administered. It must become the educational center of those doctors who work and practice therein.

It is then, the function of the visiting staff to act as counsellors for the young members of the profession (resident and intern group) and also to take part in their own continued medical education. If they are private practitioners the major part of their time will be spent in the care of the sick, but many feel that if they do not devote some time to instruction of interns, residents and nurses; that if they do not participate in various medical educational ventures such as meetings, etc.; they will eventually not be able to fulfill their primary objective (the care of the sick) to their full ability. It is often said that medical research is the prerogative of a special individual. I feel this is not so and that any hospital can offer facilities of some degree for original research. And even though this research does not result in earth-shaking publications, a philosophy is developed and mental habits are formed that are associated with the highest type of medical practice.

continued on next page

The intern and resident staff should be so organized that there is an increasing responsibility and an increasing willingness to assume this responsibility. They should be encouraged to engage in small research problems and to attend all meetings of the hospital, even some of the administrative staff meetings. If this is done, they will be far more sympathetic with the problems of the director. The intern is not a slave and should be given sufficient time for recreation and study. It is only when a service staff is highly organized so that responsibility can be delegated and shared that the intern will be able to have this time available.

Division of Services

I have mentioned above that the hospital staff should be divided into services. The Michigan State Medical Association recommends that, in addition to the usual services of medicine, surgery, etc., there be a Service of General Practice. This general practice service is organized with the Chief of Services, associates, etc.; however, the patients are usually admitted according to their diagnosis on one of the other services. When the general practitioners are organized into their own service, they can be of great value in teaching programs and feel that they have a voice of their own, and in the hospitals with which I am acquainted where this type of organization exists, it has worked out admirably. It might be asked why it is necessary to divide a hospital into services. To a physician, this seems self-evident; to the lay person, it is frequently not. However, in this age of specialization, better medical care can be given when patients are grouped according to the type of condition that affects them, for here we can employ nurses with training in special techniques; the resident staff will be attending to one general type of patient only, and many laboratory and special procedures that are normally used for a certain type of patient can be made more available to that patient.

How should the nursing staff fit into the picture of hospital organization? At the University of Michigan, nursing is considered a separate school and is organized as a third parallel staff within the hospital. The chief nurse is responsible to the Dean of the Medical School as Professor of the School of Nursing; she is responsible to the various service chiefs to see that the best possible nursing service is rendered within his department. She is also responsible to the Administrative Director of the Hospital in manners that affect him. This is truly a large bill for anyone to fill and requires a person of unusual ability. In small hospitals, the chief nurse will come directly under the hospital administrator, and as such, will be saved much of the administrative detail found in larger nursing schools. In order that a hospital staff will function smoothly, it is necessary that the duties of each individual be outlined so that responsibility can be placed for various details in the care of the sick individual. It should be outlined carefully the duties of the intern, assistant resident and resident; the visiting staff should be informed of their obligations to the hospital as well as their privileges, and in small hospitals these obligations may be considerable. For instance, the hospital which cannot attract an intern or resident staff must depend on the attending physician for history, physical examination, progress note, and the proper diagnosis and summarizing of the case after discharge. I do not feel that any of this should be relegated to the nursing staff, though this is not infrequently done. The physician should have in his office, records showing a history and physical of the patient; a copy of which can be transferred to the hospital chart if he does not have time to do these again after admission. Certainly no one but the attending physician can properly record the clinical progress of the patient. Only he, or his assistants, can record the operative note in sufficient detail, and final diagnosis is of course his obligation. This does not mean that the nursing staff does not have a large responsibility in recording their own progress notes. These are most helpful and are more detailed in some respects than the physician's progress notes. These supplement each other, and neither can be omitted without detriment to the patient.

In hospitals of any size there will be many policy-forming groups and these should be represented by both the administrative and professional branches of the hospital. Here again, we are faced with the fact that only by the closest cooperation between these two groups can the hospital give its maximum service. In formation of the budget the professional services should be represented so that they may offer guidance in certain technical matters, such as the purchase of equipment and drugs. On the other hand, the administrator may reasonably expect to standardize certain procedures and even prescriptions, so that he will not be forced to duplicate material which differs only in name.

The Organization of a Service

Let us take one service and look at it in a detailed manner rather than in the general way we have covered the hospital before. First, there will be a chief of service and under him associates, assistants, residents, assistant residents and interns. The Chief of Service will have more or less autonomy depending on his tenure, depending on whether he is full-time or part-time, and many other factors. He is, however, responsible to the

continued on page 454

The RHODE ISLAND MEDICAL JOURNAL

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TREATMENT OF BULBAR POLIOMYELITIS

THE FIRST PAPER in this month's JOURNAL is the communication by Viets of Boston to the recent annual meeting of the Rhode Island Medical Society, entitled "Neurologic Aspects of Poliomyelitis".

Editorial attention is called to this contribution because of the serious new problem which is presented. Viets has found that in the recent epidemics of poliomyelitis from 1943 to 1946 there has been an alarming increase in the proportion of cases with bulbar involvement. In the scattered epidemics these cases have amounted to over 20% of the total. In the purely spinal types the improved methods of treatment have reduced the mortality to about 1%. The bulbar cases on the other hand have shown a mortality averaging over 20%.

Viets found that the reports from Minnesota based on 100 such cases in the 1946 epidemic showed an extraordinary reduction in this mortality to 5%. Up to the present of course no known specific treatment for poliomyelitis has been found. The great reduction in mortality has resulted from careful application of certain principles of treatment which Viets outlines in the present paper.

In the first place all cases of poliomyelitis, including suspected cases, should be watched very carefully for evidence of weakness in any of the muscles supplied by the cranial nerves. This requires no complicated apparatus or special tests; merely careful use of the ordinary senses applied to clinical observation.

Attention should be paid to sudden increase in rapidity of pulse, nasal voice, difficulty in swallowing, inability to cough or expectorate, facial paralysis, oculomotor paralysis, speech disturbance, etc.

Any of the motor cranial nerves may be involved. While many of the resulting symptoms may appear alarming, most of them are of relatively minor importance. However when the 10th nerve is involved the patient's life is primarily endangered.

The general practitioner who first sees the case is the man upon whom rests the greatest responsibility in attempting to reduce the mortality in these cases. He must not wait until he finds definite signs of 10th nerve involvement. Viets believes that observation of weakness in a single muscle supplied by a cranial nerve should be the warning signal. The potential gravity of the case should be recognized, and the patient should be immediately hospitalized.

Transportation to the hospital should always be

continued on next page

by ambulance, and never with the patient sitting up. Rapid speed of transport, with police escorts and screaming sirens must be completely discarded. The slowest, smoothest possible trip is the most desirable, with the minimum of physical and mental strain for the patient. During the trip the airway should be kept unobstructed by postural drainage of saliva and mucus, with aspiration if necessary.

On arrival at the hospital a waiting team of physicians should be ready to perform immediate tracheotomy if the simpler means have not been satisfactory. When the operation is done, it should of course be followed by skillful aftercare and special nursing.

Oxygen will often be necessary if there is anxiety, restlessness, increasing pulse rate, elevation of blood pressure or other signs indicating lack of oxygen. Sometimes these signs may be due to involvement of the deeper medullary centers which control circulation or respiration. In these cases of course the prognosis is much graver.

A combination of bulbar and spinal infection has a still higher mortality, up to 40%. In these cases the respirator should be used early.

This situation has been stressed editorially at the present time in order to "alert" the general practitioner to the serious importance of recognizing the early signs of bulbar involvement, well in advance of the seasonal recurrence of the disease, which does not take place of course until late summer and early fall.

In short, Viets emphasizes the importance of early hospitalization in the bulbar cases, keeping the airway open, prompt tracheotomy, early use of oxygen, and possibly the respirator.

He feels that these cases should be treated in general hospitals, where skilled teams and trained personnel should be ready. This will of course require a complete reversal of the present policy in most of these hospitals with respect to the admission of cases of poliomyelitis. Viets however insists that the general hospital must open its doors to these cases if continued good results and sustained reduction of mortality are to be expected in the future.

GUY WILLIAM WELLS

1891-1948

The death of Guy W. Wells, on June 15, 1948, has taken from the medical profession of Rhode Island one of the outstanding physicians of his generation. With his natural gifts for leadership and friendliness he will be sorely missed, the more because of his going just when he had reached the peak of his active career.

Though a native of Pennsylvania where he received his early education, much of Dr. Wells' life was spent in Providence. After his graduation from Brown University in 1916 he gained his medical education at Cornell University Medical School, returning to Providence in 1920 as an intern at the Rhode Island Hospital. After two years of additional training as a resident physician at the Peter Bent Brigham Hospital in Boston he came back to Providence to enter the practice of internal medicine. Immediately he began an active participation as a visiting physician in the hospitals of the city to which, throughout his career, he devoted much earnest, energetic and conscientious service. One of his great interests in Medicine was in bettering patient care in hospital services and he gave generously of his time to both the outpatient and ward services of the Rhode Island, the Chapin and the Lying-In Hospitals, and to the Memorial Hospital in Pawtucket. During the last two years of his life he served as chief of the medical service in both the Memorial and the Rhode Island Hospitals.

Dr. Wells' interests in the field of Internal Medicine were general rather than specialized, though he gave particular attention to thyroid and other endocrine disorders, to cardiovascular disease and, in his later years, to diseases of the liver. While at heart he was a clinician, and in practice a very thoughtful and practical doctor, endowed with sound judgment, human understanding and that rare gift of common sense, yet he loved the study of physiology and the basic functions of the body. One often heard him advising younger doctors to keep up their grounding in basic sciences, a practice which he himself greatly enjoyed following whenever time for reading and study came his way.

Few doctors encumbered with a busy practice of medicine have given as liberally of their time and energy as did Dr. Wells to the work of their local and state medical societies. He served from 1936 to 1941 as secretary of the Rhode Island Medical Society and during 1947 was president of the

Providence Medical Association. For a number of years he was a member of the House of Delegates of the state society and both before and after World War II served as the member from Rhode Island to the House of Delegates of the American Medical Association. He was active also on many committees of both the local and state societies. To all of these offices he devoted conscientious time and thought. They were not to him titles of prestige and importance, but appointments that called for study and action.

The same zeal that characterized Dr. Wells' devotion to Medicine, to his patients, and to medical societies, stood out in his allegiance to his country. He was conspicuously a patriot with a deep interest in all that true patriotism calls for. Soon after entering practice in 1924 he joined the Medical Reserve Corps of the Army as a first lieutenant, and by study and periods of training rose to the rank of major in that organization. In July, 1941, he was called to active duty, being made Chief of the Medical Service of the Station Hospital at Camp Devens, Massachusetts. For a period in 1942 he was assigned to special duty for the procurement of medical officers in Rhode Island, and then, with the activation of the 52nd Station Hospital, to that unit as Commanding Officer. His was among the first units to land in North Africa after the invasion, and there his hospital, located in Oudja, had a distinguished record throughout the African campaign. With the invasion of Italy, the hospital was moved to Naples. Dr. Wells remained at its command through all the months of the Italian campaign and made of it an organization whose spirit and record was one of distinction. On release from active duty after the war he continued his leadership in the Organized Reserve Corps of the Army by building up a Hospital Ship Complement in Providence. It is appropriate to quote here, as a tribute to his devoted service and patriotism, two messages from his superior officers sent to his wife on learning of his death:

From General Mark Clark:

. . . His unselfish devotion to duty during our campaigns in Italy endeared him to us all. Together with his countless friends I salute the passing of a loyal soldier and a real friend to man. . . .

From Brig. Gen. J. J. Martin, MC., U. S. Army:

. . . American medicine and particularly the Army, which he loved so much, have lost a pillar of strength which can never be replaced. As a doctor, a military leader, and a gentleman he had no peer. The many thousands of his comrades who were carried through the trying days of the last war by his unfailing cheerfulness and his uncanny ability to lead the way to the best horizons will bear into eternity the mark of his presence. . . .

One of Guy Wells' great gifts was his genuine capacity for friendship. He was endowed with that kind of warmth of greeting and sympathy that attracted people naturally and his friends were legion, their devotion to him great. Everyone liked Guy Wells. One could not escape knowing the force of his convictions or annoyances for he voiced them freely, with earnest emphasis and with carefully considered reason, and almost always with a smile. He was outstandingly a gentleman; tolerant and considerate of the feelings of others. He could accept an opposing view that to some would bring irritation by a serene dismissal, "Well, that is very interesting",— yet there was no lack of "righteous indignation" in his makeup, and he would not hesitate to voice it when it was called for. In all of his positions of leadership it was invariably his way to seek counsel from those under him and make them feel they shared leadership with him. The iron hand of authority was as foreign as friendliness and co-operation were natural to him, and a smooth running organization was the result when he was in command. With all of his interests and accomplishments he was very much a family man. No one was ever more devoted to his home and his family nor took greater pride in his household and his children. The world can ill afford to lose men of the stamp of Guy Wells.



GUY W. WELLS, M.D.
1891-1948

GENERAL SESSION

THE RHODE ISLAND MEDICAL SOCIETY

May 13, 1948

PRESIDENT RUGGLES: The by-laws of our Rhode Island Medical Society provide that during the Annual Session, there shall be at least one general session at which any members of the Society may present any business of concern to the profession. I declare this to be the general meeting of this session, and at this time I am going to ask our Secretary to report on the list of officers.

SECRETARY CUTTS: As there have been regular reports throughout the year to the House of Delegates on the business of the Society and on the meetings of the Council, this report will be limited to reading the names of the officers and the Chairmen of the elected committees for 1948-1949. The slate of officers is as follows:

For President	Joseph C. O'Connell
Vice-President	Edgar S. Potter
President-Elect	Peter Pineo Chase
Secretary	Morgan Cutts
Treasurer	Charles J. Ashworth
Assistant Secretary	Charles B. Ceppi
Assistant Treasurer	G. Raymond Fox

For the Standing Committees prescribed by the by-laws:

Committee on Scientific Work, Isaac Gerber

For Chairman of the Committee on Public Policy and Relations, Charles L. Farrell.

For Chairman of the Committee on Public Laws, William H. Foley.

For Chairman of the Committee on Post-Graduate Education, Marshall Fulton.

For Chairman of the Committee on Medical Economics, William P. Davis.

For Chairman of the Committee on Industrial Health, Stanley Sprague.

For Chairman of the Committee on Library, Herbert G. Partridge.

For Chairman of the Committee on Publications, John E. Donley.

That concludes the regular standing committees of the Society, Mr. President.

PRESIDENT RUGGLES: Thank you, Dr. Cutts.

It is now my great pleasure to present to you your new President, Dr. Joseph C. O'Connell. I am going to ask Dr. McLaughlin and Dr. Henry Moore to escort Dr. O'Connell to the platform. [Applause]

PRESIDENT O'CONNELL: Ladies and Gentlemen, I wish to take this opportunity to thank the members for my election to the Presidency of our Society. I really feel that it is a distinct honor. The office has been held by many distinguished members of our profession, not the least of whom is my predecessor in office. I do not expect to preside with the charm and the poise of Dr. Ruggles, but I shall do my best to keep the ship on an even keel, to be turned over next year to our President-Elect, Peter Pineo Chase.

The present committees for the coming year were made up, but they have not yet been published. I hope that the members will accept their appointments, and I am asking the Chairmen of the Committees to hold their meetings only when possible and then to notify the members sufficiently in advance so that they may be able to arrange their work to allow them to attend the meetings. I also suggest that they be supplied with a copy of the agenda of meetings, so that there may be a free discussion of the actions taken, so that it will be the action of the committee and not that of the Chairman.

I wish to thank Dr. Ruggles for the many courtesies shown to me during the past year. I also wish to ask the cooperation of the officers and the members of the society for the coming year.

Is there any business to be brought before the Society at this time?

If not, I will entertain a motion to adjourn.

Upon motion duly made and seconded, it was voted to adjourn.

PROVIDENCE MEDICAL ASSOCIATION

Next Meeting

MONDAY, OCTOBER 4



DR. J. C. O'CONNELL INDUCTED

Dr. Joseph C. O'Connell (left) new President of the Rhode Island Medical Society receives the official gavel from retiring President, Dr. Arthur H. Ruggles, while Dr. Peter Pineo Chase, President-Elect, views the proceedings.

HEALTH EDUCATION FELLOWSHIPS

The American Cancer Society has authorized the expenditure of $10,000 for fellowships in health education. The present proposed plan is to offer eight fellowships of $2,500 each (to be borne half by the Society and half by the state division) for graduate study in any one of the five approved schools of public health which include Yale University and the State Universities of California, Michigan, Minnesota and North Carolina.

The national office will name a Committee on Fellowship Awards who will make final selections from names submitted by state divisions. The applicant must have a B.S. or B.A. degree from an accredited school along with other specific requirements.

The eight selected students will obtain a nine months' study period and three months' supervised field training. Divisions may be permitted to contact the applicant for two to three years of service at the completion of the year's fellowship.

In addition to the above mentioned eight fellowships, several of the state divisions have already offered full fellowships within their own state budget.

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THE ANNUAL DINNER

137th Annual Meeting of the Rhode Island Medical Society

MAY 12, 1948

Guy W. Wells, M.D., *Presiding*

Anniversary Dinner Chairman

Dr. Ruggles, Your Honor, Your Excellency, Guests, Ladies, and members of the Rhode Island Medical Society.

During the past few years the medical profession, as represented by the Rhode Island Medical Society, has been very deeply concerned about the provision of adequate medical care for the low income groups and has conducted within the Society many very detailed studies. We are gratified to know that our Chief Executive, Governor John O. Pastore, has also been keenly interested in the welfare and the health of our people, and this movement, and has recommended and sponsored legislation appropriating funds to pay for the hospital care of such citizens. It is because of this alert and sincere cooperation of our Governor that it has been a pleasure to have him as our guest. It is unfortunate for us that Governor Pastore could not attend this dinner; he has, however, very kindly sent his representative, Lieutenant-Governor John S. McKiernan.

It is with pleasure that I shall now call upon His Excellency, Lieutenant Governor John S. McKiernan.

Honorable John S. McKiernan

Lieutenant-Governor of the State of Rhode Island

Dr. Wells, Dr. Ruggles, and other officers and members of the Rhode Island Medical Society and members of the Ladies Auxiliary, Guests, Ladies and Gentlemen.

In the absence of your good Governor, John O. Pastore, I deem it a great honor and a privilege to bring to your wonderful organization as it meets here attending its 137th Annual Dinner, the greetings on behalf of over 700,000 people. We know that you gather here yearly to renew acquaintances and also to exchange ideas and papers from which you, as individuals, receive the direct benefit, and from which the citizens as a whole receive the indirect benefit.

The Governor and the people of Rhode Island are proud of the way the members of your organization have contributed to the public welfare and the health of our great state. You have been directly responsible for great movements, like the clearing of the pollution problem, the purification of air, the encouragement of and modernization of pasteurization of milk, and also alleviating and improving the industrial working conditions of our laborers. We are proud of these contributions, and I know I speak on behalf of over 700,000 people when I say that they are also proud of these contributions made by your Society to our citizenship here in Rhode Island.

We of the present administration are always willing to cooperate in any way we can with your organization. We know that you have the finest and the highest standards in your profession, and that you bring to your Association men of high moral and intellectual balance.

In the absence of your good Governor, I want to congratulate each and every one of you on your 137th Annual Dinner, and to wish you all good health, and may you all continue to make the same fine achievements and improvements to our public life in the future as you have done in the past.

The Dr. Charles V. Chapin Award

As you know, the Providence Medical Association, composed of members of this Society, is celebrating its 100th Anniversary, and all of us are proud of one hundred years of continued service of the Association, both to the medical profession and to the public.

continued on page 446



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*Levin, S. J., and Moss, S. S.: Clinical Results with Hydryllin in Asthma and Hay Fever, to be published.

CHARLES V. CHAPIN AWARD

continued from page 444

The minutes of the first meeting reported a Committee of two members waiting on the Mayor to advise him on health matters for the city. I shall not go into the subject, but it was interesting. I think it was one hundred years ago this month that that occurred.

Particularly for the benefit of the out-of-town guests, I should like to say that the Rhode Island Medical Society and the Providence Medical Association are still meeting with the Mayor, and we are enjoying a very fine relationship with the city government. In recent years, we have conferred with Mayor Roberts, and we have not only been welcome, but have received his fullest cooperation.

I recall the early efforts of initiating action in such problems as air polution, when the Mayor led a campaign which resulted in a city ordnance, and the Division of Smoke Control in the City Engineer's Department. And again, we stimulated interest in the better sanitation of eating places, and Mayor Roberts used his influence to carry through our recommendations. The City Council was most responsive.

I mention these examples briefly, merely to remind you that our efforts were for better community health and continued to meet with strong and willing support from the several leaders of Providence and Mayor Roberts may properly be recognized for his sincere and cooperative interest in health improvements.

As you know, it was as Director of Public Health in Providence that Dr. Chapin made his contributions that have influenced public health throughout the world. The City Council, in recognition of this work, have created an award to be given yearly to the Chapin Orator addressing the Rhode Island Medical Society at the Annual Meeting. This afternoon we listened to a splendid address on the subject of "Industrial Health" by Dr. Philip Drinker, Professor of Industrial Hygiene of Harvard School of Public Health. Dr. Drinker is the author and co-author of text books on "Industrial Health"; he is co-inventor of the Iron Lung, which has done so much for the victims of poliomyelitis. He has done more than any one else in the ventilation of submarines, and he has been the recipient of many honorary degrees; he has been awarded the John Towne Medal of the City of Philadelphia. He is a member of the American Public Health Association, American Chemical Society, American Heating and Ventilating Engineers, and the American Association of Industrial Health.

He is the only non-medical man who has been the recipient of this Award.

I am happy to present to you now Mayor Dennis J. Roberts, who will present the greetings of the City of Providence, and I am going to ask him, on this occasion, to make the presentation of the Chapin Medal to Dr. Philip Drinker.

Honorable Dennis J. Roberts

Mayor of the City of Providence

Dr. Wells, Distinguished Guests, Dr. Drinker, to whom we are to make the Charles V. Chapin Medal Award, Ladies and Gentlemen.

I am very happy to present, on behalf of the City of Providence and the Rhode Island Medical Society, the Charles V. Chapin Medal Award to this distinguished Doctor, Dr. Philip Drinker, who has contributed so much to the welfare of the United States, because of his very profound and intensive research in industrial hygiene, which we all realize is of tremendous importance to every community within our country.

I know that the doctors assembled here, and their friends, are very much aware of his contributions to the health of our country and to the health of our industrial communities.

I think that we are all grateful to him because of his contribution in the development of the iron lung. I think that we all realize thoroughly what that has meant to many an unfortunate person who has been afflicted with infantile paralysis.

Perhaps that is not his greatest contribution to science, but it is one that is outstanding, and one that touches us all.

I want to assure the doctor that the people of Providence and those of the medical profession have a great deal of admiration and respect for his application of his very adequate talents, his profound intellect in behalf of the people of the United States, and his intensive research and development of procedures that have been given in the form of advanced industrial hygiene providing the people an opportunity to enjoy a better health standard.

It is my pleasure, Dr. Drinker, on behalf of the Rhode Island Medical Society, and on behalf of

continued on page 448

immediate symptomatic relief of ocular allergies



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THE ONLY ANTIHISTAMINIC EYE DROP NOW AVAILABLE, Antistine Ophthalmic Solution gives almost immediate symptomatic relief of ocular allergies in contrast to the less rapid action of oral antihistaminic therapy. One drop every 3 hours is usually sufficient. Available as 0.5% solution in 15 cc. bottles with dropper.

ANTISTINE IS ALSO AVAILABLE IN TABLET FORM for the systemic treatment of other general allergic symptoms. This new drug has been found effective in patients where another antihistaminic has failed or where side effects have necessitated discontinuation of therapy. Dosage is usually 3 to 4 tablets daily. Available as 100 mg. scored tablets.

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MAYOR DENNIS J. ROBERTS

continued from page 446

the people of the city of Providence, to present to you the Charles V. Chapin Memorial Award. It is an award in honor of one of the most distinguished men of the medical profession of the State of Rhode Island. We are very proud of his reputation and of his contribution, and we are very proud of the distinction he has brought to this little city of ours, and to have you receive this Award means to the people of Providence that you stand with him as one of the distinguished benefactors of public health in the United States of America.

I present this Award to you, Doctor, on behalf of the 253,000 people of the City of Providence, and your distinguished colleagues.

Presentation of Gavel to Dr. A. H. Ruggles

TOASTMASTER WELLS: It is our custom to present to the retiring President of this Society a symbol of appreciation of the Society for the future. I presume other societies have a similar tradition. Dr. Ruggles must be very familiar with this ritual, for I find that he has been President of both the County and the State Medical Societies of Providence and Rhode Island, and President of the New England Society of Psychiatry, President of the National Committee on Mental Hygiene, President of the Society of Neurology and Psychiatry, Secretary-Treasurer and President of the American Psychiatric Association, one of the six delegates to the International Congress for Mental Hygiene in Paris in 1937. Here, we know Dr. Ruggles as Director of the splendid institution, Butler Hospital, a hospital that has contributed so much to the study of psychiatric problems and is now under his administration carrying out such a fine research program.

Dr. Ruggles, the Rhode Island Medical Society is deeply appreciative and grateful to you.

DR. RUGGLES: Dr. Wells, and members of this Society. I appreciate very much this tribute of the year's service. It has been a year of problems, complexities, of difficulties, and sometimes of frustrations; yet, it has been a splendid challenge of cooperative work, not only among the Committees of the Medical Society, but with the splendid help of the Women's Auxiliary, I feel that we have made progress and we have made it together. We must stand together in these difficult and complex days for the advancement that the President of the American Medical Association has so clearly put before us for the benefit of all of the people, through the medical profession.

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CHARLES DUNBAR, M.D., 10 Appian Way, West Barrington

CHARLES E. BROCHU, M.D., 38 Hamlet Avenue, Woonsocket

FRANK A. STEWART, M.D., 34 Bull Street, Newport

EDWARD A. KOSTYLA, M.D., 15 Washington Street, West Warwick

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With THENYLENE, severe side-reactions are rare. In a recent study on a large number of cases, the investigators reported that with a dosage of 100 mg. of THENYLENE, the incidence of undesired reactions was only about 25 percent, obviated in practically all instances by reducing the dosage to 50 mg.[1]

Try THENYLENE in cases where your experience with other antihistaminics has been disappointing. Leading allergists point out that one agent may bring definite relief where another has failed. For severe symptoms 100 mg. of THENYLENE three or four times daily is suggested. As a maintenance dose or for mild symptoms, 25 to 50 mg. may be prescribed. It is recommended that antihistamine drugs be used with specific desensitization wherever possible.

Prescription pharmacies everywhere have THENYLENE Hydrochloride in 25-mg., 50-mg. and 0.1-Gm. sugar coated tablets in bottles of 100 and 500. For a FREE SAMPLE and literature, drop a card to ABBOTT LABORATORIES, North Chicago, Illinois.

1. Friedlaender, A. S. and Friedlaender, S., Amer. J. Med. Sc., in press.

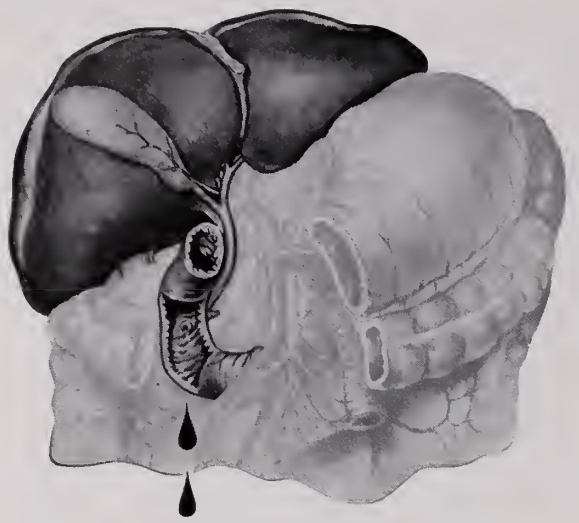
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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.

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AMES COMPANY, INC.
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NEUROLOGICAL ASPECTS OF POLIOMYELITIS

concluded from page 429

poliomyelitis is to be kept at five percent or less. Such a rate can only be maintained, when an epidemic with a high proportion of bulbar cases strikes a community, by cooperation of the public health officials, physicians, hospitals, ambulance services and nurses. Plans should be made long in advance so that special teams and adequate facilities will be ready. In recent years poliomyelitis has suddenly swamped hospitals in New Haven, Connecticut, Denver, Colorado, Minneapolis, Minnesota and smaller communities such as Hickory, North Carolina. On this point alone, it would seem advisable for every community to have a poliomyelitis commission whose chief duty would be to outline plans for the care of patients in an epidemic in their community. This can be done through the aid of the National Foundation for Infantile Paralysis but it is primarily a public health, hospital and physician's responsibility and they are the ones who should learn the lesson from the experience of a community such as occurred in Minneapolis in 1946. Every general hospital must open its doors to poliomyelitis if good results are to be expected in the future. The rest lies with you.

References

[1] Minnesota Poliomyelitis Research Commission: The Bulbar Form of Poliomyelitis. I. Diagnosis and the Correlation of Clinical with Physiologic and Pathologic Manifestations, J.A.M.A. 134:757-762 (June 28) 1947.

[2] Piszczek, E. A.: Treatment of Bulbar Poliomyelitis, Amer. Practitioner. 2:16-18 (Sept.) 1947.

[3] National Foundation for Infantile Paralysis. Annual Report for the Year ending May 31, 1947. pp. 86. New York: 1947.

[4] Minnesota Poliomyelitis Reseach Commission: Bulbar Form of Poliomyelitis. II. Therapeutic Measures Based on Pathologic and Physiologic Findings. J.A.M.A. 135:425-428 (Oct. 18) 1947.

[5] Kubicek, W. G.; Holt, G. W.; Kottke, F. J.: Physiology of Respiration as Applied to the Treatment of Bulbar Poliomyelitis, Arch. Physical Med. 29:84-88 (Feb.) 1948.

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1 Gallbladder emptying is better stimulated by bacon's traditional companion-in-the-pan, the egg; the yolk preferred, and of course, unfried. Butter and cream do as well.

2 Utilization of the fat is aided by giving Doxychol-K; its desoxycholic acid content is noted for efficient transport of fatty compounds across the intestinal mucosa.

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DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport County Medical Society was held at the Newport Hospital on Tuesday evening, May 25, 1948, with sixteen members attending.

The meeting was called to order at 9:05 p. m. by Dr. Henry Brownell, Vice President. At 9:30 p. m., Dr. Philomen P. Ciarla, President, took over.

There was no old business.

Numerous communications were read.

Dr. Samuel Adelson moved that although the Society is in agreement with the content of the communication of May 4, 1948, from the Rhode Island Medical Society, a definite written agreement should be made with each Insurance Company and that this Society should be given a list of those companies that agree to the increased fee. Dr. MacLeod seconded. It was approved.

Dr. Adelson suggested that a Chairman be appointed to investigate the Newport Hospital's Laboratory fees to outside private patients and also suggested a communication be sent to Dr. Edward A. McLaughlin, State Director of Health, expressing regret that the State Health Department has has had to discontinue blood chemistry examinations.

New Business: A committee of Drs. George Eckert, chairman, Samuel Adelson, Norman MacLeod and Charles Dotterer was appointed to work with the Rhode Island Medical Society for arranging a possible site here for the next annual Meeting of the State Society.

Dr. Norman MacLeod stated that the Board of Health plans to eliminate tuberculosis in the County and asked the cooperation of the Doctors to report cases of tuberculosis early and to support the drive that is planned.

Dr. Brownell moved that a lot of fifty official A.M.A. M.D. emblems with the name of the Society attached be purchased by the Treasurer and sold to members at cost. Dr. Adelson seconded. Motion approved.

Dr. Norbert Zielinski, treasurer, reported that as of May 25, 1948, the Society had $308.00 in cash, $392.00 due the Society and no outstanding bills.

Dr. Samuel Adelson moved that the President, Secretary, and Treasurer be a committee with power to make concessions for members with long unpaid dues where any hardships might be involved. Dr. MacLeod seconded. Motion passed.

Dr. Charles Dotterer made a motion which was seconded by Dr. John Malone and passed that the Newport County Society adopt the payment of dues procedure of the Rhode Island Medical Society that "any member with respect to whom dues for that year have not been received by the Treasurer by October 1, after sixty days notice by the Treasurer, shall be suspended from membership in this Society."

The meeting adjourned at 10:20 p. m. Collation was served.

Respectfully submitted,

JOHN M. MALONE, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was called to order by the President, Dr. Earl Mara, May 20, 1948, at 6:30 p. m. in the Nurses' Auditorium of the Memorial Hospital.

The minutes of the previous meeting were read by the Secretary and accepted.

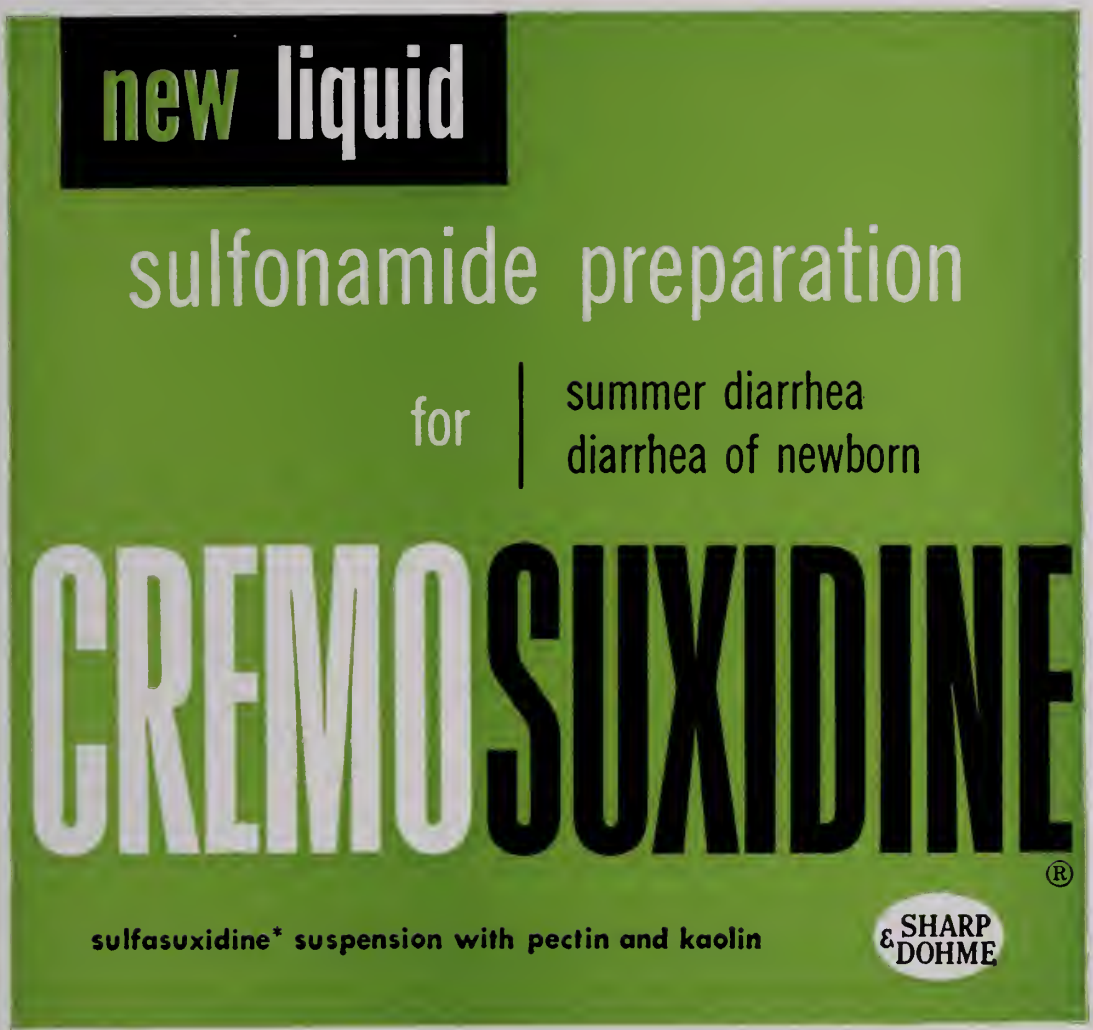
A communication from John E. Farrell, Executive Secretary of the Rhode Island Medical Society was read. This called attention to the recommendation adopted by the House of Delegates relative to the increased fee rate for insurance examinations.

Another communication from the Washington County Medical Society deploring the recent discontinuation of blood chemistry examinations by the Rhode Island Division of Laboratories was read. Dr. Edward Foster presented a similar statement, signed by members of the Staff of the Memorial Hospital. Following some lengthy discussion, this matter was tabled.

The application for membership in the organization was read from Dr. Alice Madros Kechijian Bandeian. This was referred to the Standing Committee.

The application of Dr. Andrew Gerard Czekanski, having the approval of the Standing Committee, was submitted to ballot and unanimously accepted.

continued on page 454



Mortality in the neonatal group of patients has shown a persistent upward trend,[1] and may "*be attributed in large measure to the prevalence of epidemic diarrhea of the newborn infant.*"[2] Overcrowding and understaffing of hospital nurseries are important contributing factors, and until these war-induced conditions can be corrected, particular emphasis must be placed on isolation and prompt control.

CREMOSUXIDINE,® a palatable, highly effective new preparation developed by Sharp & Dohme, aids management of diarrhea regardless of its cause. A chocolate-mint flavored suspension of succinylsulfathiazole (10%), pectin (1%), and kaolin (10%), CREMOSUXIDINE acts promptly to consolidate stools, eliminate products of putrefaction, soothe inflammation, and check bacterial infection.

Dosage: Infants and children in proportion to adult dose of 2 to 3 tablespoonfuls 4 times daily. CREMOSUXIDINE is supplied in pint bottles. Sharp & Dohme, Philadelphia 1, Pa.

*Registered trademark of Sharp & Dohme

1. Frant, S., and Abrahamson, H.: *Brennemann's Practice of Pediatrics*, 1:28:22, 1945.
2. Blattner, R. J.: *J. Pediatrics*, 32:220, February, 1948.

CREMOSUXIDINE

PAWTUCKET MEDICAL ASSOCIATION

continued from page 452

Dr. Charles L. Farrell gave a report of the recent meeting of the House of Delegates. The delegates from the Pawtucket Medical Society were instructed to reaffirm their stand in the recent controversy regarding the Dean's Committee for the Veterans' Hospital.

Dr. Charles Farrell, Program Chairman, introduced the Speaker of the evening, Dr. William McDonnell, Staff Anaesthetist, St. Joseph's Hospital, Providence. Dr. McDonnell's topic was "Responsibilities of the Anaesthetist." Following his paper, Dr. McDonnell gave an enlightening informal discussion on the problem of acute cardiac arrest and made a plea for standing orders and immediately accessible equipment to meet this emergency.

The meeting adjourned at 8:45 p. m. Twenty-two members attended.

Respectfully submitted,

Kieran William Hennessey, m.d.,

Secretary

FUNDAMENTALS OF STAFF ORGANIZATION

continued from page 438

chief of staff of the hospital and in many matters will go through him to the director. He must, however, have access to the director on certain matters. This again will vary considerably depending on whether he is full-time or not. The Chief of Service will assign ward work and the rotation of staff patients to the members of his staff. He will either be in charge of the Out-Patient Clinic or will delegate this authority to one of his subordinates. He will be responsible for the budget for his particular service and professional matters. In case the service concerned has residents training for a specialty, it will be his responsibility to see that their training program is adequate and that they are fairly treated by the administrative service of the hospital. I will go into this matter in considerable detail during the next hour. In case the hospital has other than private patients, he will be expected to make rounds on all staff patients at frequent intervals, and in some hospitals where only private patients are admitted, this is also expected. I know that this sounds strange to some of you, but I can point out hospitals in this country where only private patients are admitted and where the Chief of Service makes daily teaching rounds not only with the resident and intern staff, but also with students. If the calibre of the staff and the calibre of the Chief of Service and his associates is such that this is practicable, this will, I believe, lead toward better care for the individual patient.

If the hospital under consideration is not training specialists, but training men for general practice, then the rotation of the resident and intern becomes a responsibility of the Chief of Staff of the educational committee. This does not, however, absolve the Chief of Service from his responsibility of teaching the resident and intern staff.

It is also the responsibility of the Chief of Service to see that the records on his service are adequate, that certain medical legal problems are solved properly, such as the dispensing of narcotics, etc.

Role of Administration Staff

The administrative staff will be largely concerned with administrative matters and will in all probability relegate all professional authority to the attending staff through the Chief of Staff. There is one point, however, where they are directly concerned with patients, and that is in the building of good will towards their hospital. The reputation of an excellent institution is easily shattered by a snippy reception clerk, and all patients, regardless of their social and financial status, should be treated with the utmost courtesy and consideration during the time that routine admitting procedures are being carried out. It may seem unnecessary to stress this, but in a large institution all too frequently every patient feels that he is only a number and no one has any particular interest in his problem.

Certain procedures should be flexible enough to allow for the very ill patient to be admitted directly to a bed and the registration data obtained from a relative or at the bedside. This may be expensive, but not only will the hospital be building a reputation for courteous service, but the physician's job will be much easier. There are few doctors who cannot cite the experience of trying to calm a patient that has been riled up by the admitting staff before his medical workup can be instituted.

Consultation service within the hospital varies in different parts of the country. In some hospitals, with an open staff, any member of the staff may be called in consultation. In other hospitals, with closed staffs, certain members are designated as the consultant staff and only these may be used as consultants. This is one of the factors that can only be evaluated in light of local conditions and the recommendation as to its advisability could only be made if one had at hand all the factors concerned.

There are many types of staff organizations and most of them work to some extent. The most important thing about staff organization is that all members of the hospital staff, no matter what their duties may be, should have some insight into the general problems of the institution and a willingness to cooperate with all other members of the hospital so that the patient may be served more effectively.







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thus have the major advantage of assuring sustained therapy for patients of varied occupations —the executive under pressure of time, the business man who travels, the factory worker who cannot leave his job. Increased demand for the male sex hormone preparations in turn has recently permitted price reductions of from 35 to 50 per cent. As a result, many more patients are now able to have the benefit of continuing and effective testosterone therapy for hypogonadism, the male climacteric and other conditions where testosterone therapy is beneficial.

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ANNUAL REPORTS

MAY, 1947 — MAY, 1948

THE RHODE ISLAND MEDICAL SOCIETY

ANNUAL REPORT OF THE TREASURER — 1947

During the past year the funds of the Society have been consolidated for more efficient administration of the financial affairs of the organization.

Notable building repairs have been completed, including the installation of modern lighting for the auditorium, the reading room, Miller room and stairways. In addition the reading room and stair halls were painted, and minor repairs made about the library building.

The general high cost of all commodities and services is reflected in our expenditures for the year, with increased outlays necessary for public utilities, printing, fuel, library and office supplies, books, the annual meeting, etc. In addition the Society has assumed added expense in connection with the voluntary prepaid surgical insurance program which has involved many conferences, the printing of literature, and legal services.

The Library building and its contents have been carefully checked by insurance experts and insurance to protect the investment of the Society has been purchased, involving increased premium charges

Within the year the tax status of the Society was reviewed by the Office of the Commissioner of Internal Revenue in Washington in the light of the decision in American Medical Association v. Board of Review of Department of Labor (Ill. 1946) with the result that we are no longer entitled to exemption under the provisions of section 101(6) of the Internal Revenue Code. This latter section provides for exemption for an organization *exclusively* educational, scientific, religious, or charitable. On advice of legal counsel we have not appealed this which makes us subject to social security taxes for employees, but not subject to income tax.

We completed the year with a cash balance in the general operating fund (total general fund less cash credited to the account of Special Endowment Funds) of $7,027.86. This is hardly a sizeable surplus, especially when viewed in the light of cash reserves maintained by other state, and even county medical societies. For example, a district medical society in a neighboring state, in an area comparable to greater Providence, recently reported a cash reserve of more than $38,000.

In the long range planning for the Society, as advocated by the special budget committee of the Council two years ago, recommendation was made that an effort be made yearly to allocate some of our surplus for a reserve or contingency fund. In keeping with that recommendation, therefore, I would suggest to the Council that $3,000 of our present general fund be invested, possibly in government bonds, and set aside with the $2,000 already owned in U. S. Treasury securities, as a contingency fund of the Society.

I direct the attention of the Society to the fact that other than the special Charles F. Gormly Fund created by the Council with the small surplus accruing from contributions from members to purchase the oil painting of Dr. Gormly in 1943, we have received no bequests since the Davenport Fund was established in 1930. It does seem as if some members of the profession, or friends of the profession, might be willing to establish while living, or otherwise as legacies, endowments to their own or others memories, whereby the education of physicians in general might be advanced, and the objectives or the medical profession and the Rhode Island Medical Society might be financially supported. I would recommend that the Council and the House of Delegates give this proposal very serious consideration, and that an official committee of the Society be considered to make a study with recommendations, or even to solicit funds for the endowment of our Society.

Financial Statement, 1947

Recepits, 1947, (Exhibit A)	$33,073.18	
Expenses, 1947, (Exhibit B)—29,553.17		
Cash Operating Surplus, 1947		$3,520.01
General Fund, Cash on deposit, January 1, 1947		5,416.42
General Fund, Cash on Deposit, January 1, 1948		$8,936.43

* * * *

General Fund, January 1, 1948	$8,936.43

continued on page 458

QUESTION:

When is it good practice to suggest "Change to Philip Morris Cigarettes"?

ANSWER:

When patients under treatment for throat conditions persist in smoking, many eminent nose and throat specialists suggest *"Change to Philip Morris"** ... the *only* cigarette proved** less irritating.

● ***In fact, for all smokers, it is good practice to suggest "Change to Philip Morris."***

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**Reprints of published papers on request:
Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

ANNUAL REPORTS

continued from page 456

Less Cash credited to the account of Special Funds (Exhibit C)	—1,908.57
General Operating Fund, January 1, 1948	$7,027.86

* * * *

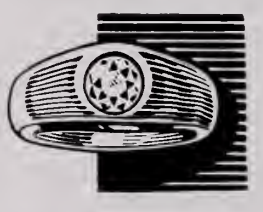
Invested Funds (General Account), U. S. Treasury Securities	$2,000.00
Total Cash Assets (General Fund) January 1, 1948	$10,936.43

Exhibit A

Receipts, 1947

Annual dinner payments	$ 1,296.00
Council, payment by members for dinners at meetings	201.00
Dividends from investments	637.30
Donations	71.55
Dues from members	25,746.45
Ely Fund, 52 shares of R. I. Public Service stock recalled	858.00
Exhibits, balance for 1947 meeting	1,046.00
Exhibits, deposits for 1948 meeting	1,057.50
Miscellaneous	11.30
Providence Medical Association	2,148.08
TOTAL	$33,073.18

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Exhibit B

Expenses, 1947

Annual Meeting (including dinner payments)	$ 2,639.64
Books	210.59
Committees	375.51
Delegates to A M A House of Delegates meetings	218.00
Donations and Dues	180.00
Electricity	55.33
Essay Contest (Cash Prizes)	175.00
Fuel	1,138.85
Gas	42.50
Insurance (Fire, liability, property damage, annuity)	1,085.20
Legal	984.72
Library (miscellaneous)	132.53
Mid-winter meeting	83.49
Miscellaneous (Society and executive office)	490.70
Office supplies and equipment	512.68
Postage	337.14
Printing	535.44
Repairs to Library (including new lights, painting, etc.)	3,840.69
Salaries	16,079.90
Social Security Taxes	192.00
Telephone	220.14
Woman's Auxiliary	23.22
TOTAL	$29,553.17

Exhibit C

SPECIAL FUNDS

J. W. C. ELY FUND

A memorial fund established in 1912 by the son and the granddaughter of Dr. J. W. C. Ely, in the amount of $1500, to be called the J. W. C. Ely Fund and the income from which was to be used for periodicals.

Investments

52 shares, New England Electric Company	$ 624.00

Cash in General Fund of Society

R. I. Public Service Co. stock recalled, 1947	$ 858.00	
Cash balance from unused dividends, 1946	40.65	
Stock dividends, 1947	78.00	
		$ 976.65

Periodicals purchased, 1947	—128.50	
Cash balance in General Fund, January 1, 1948		$ 848.15

* * * *

Endowment Fund

Started in 1912 when the Trustees (of the Fiske Fund) announced that they had voted to take the remuneration allowed them by the will, i.e., 2/12 of the annual income, amounting that year to $69.69, and to present this sum to the Rhode Island Medical Library to be the foundation of a "maintenance fund" for the support of the Library Building.

Investments

16 shares, National Bank of Commerce	$1,200.00
74 shares, Providence Gas Company	906.50
Dividends, 1947, (Used for Library Building repairs)	$ 88.70

E. M. HARRIS FUND

Established in 1921 by a donation of $5,000 by Dr. E. M. Harris for "upkeep of the Library Building".

Investments

25 shares, Consolidated Edison Electric Company		$2,346.88
64 shares, Nicholson File Company		2,719.00
Dividends, 1947, (Used for upkeep of Library building)		
Consolidated Edison Electric Company	$ 125.00	
Nicholson File Company	170.20	
		$ 295.20

* * * *

HERBERT TERRY FUND

Established in 1928 by a donation of $2,000 from C. B. and C. H. Kenyon in memory of Dr. Herbert Terry, for the purchase of books and periodicals and for the binding of same for the Library.

Investment

96 shares, Providence Gas Company	$1,152.00

Cash in General Funds of Society

Cash balance from unused dividends, 1946	$ 19.40	
Dividends, 1947	52.80	
		$ 72.20
Books and periodicals purchased, 1947	—63.00	
Cash balance in general funds, January 1, 1948		$ 9.20

* * * *

JAMES R. MORGAN FUND

Established by a donation of $500 in 1929 to be used for current expenses.

Investment

43 shares, Providence Gas Company	$ 526.75
Dividends, 1947, (Used for current expenses)	$ 23.65

JAMES H. DAVENPORT FUND

Established in 1930 by a donation of $1,000 for the purchase of books for the Davenport Collection of non-medical books written by physicians.

Investment

89 shares, Providence Gas Company	$1,068.00

Cash in General Fund

Cash balance, January 1, 1947	$ 949.09
Dividends, 1947	48.95
	$ 998.04

continued on next page

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ANNUAL REPORTS

continued from preceding page

Books purchased, 1947	—15.04	
Cash balance in General Fund, January 1, 1948		$ 983.00

THE CHARLES F. GORMLY FUND

Established by the Society in 1945 with a cash balance of $102.51 accruing from surplus contributions from members of the Society for the purchase of an oil painting of Dr. Gormly presented to the Society in 1943. The Fund was established for the purchase of medico-legal books to form the Charles F. Gormly collection.

Cash balance in General Funds, January 1, 1947		$ 72.27
Books purchased, 1947		4.05
Cash balance in General Fund, January 1, 1948		$ 68.22

* * * *

FRANK L. DAY FUND

Established is 1927 by a donation from the estate of Dr. F. L. Day, to be utilized for the purchase of books.

Investment

3,000 shares, Canadian National Railway Company		$2,979.75
Cash, Industrial Trust Company, checking account		
Balance, January 1, 1947	$ 784.59	
Dividends, 1947	135.00	
	$ 919.59	
Books purchased, 1947	227.90	
Balance, January 1, 1948		$ 691.69

CHARLES J. ASHWORTH, M.D.,
Treasurer

THE FISKE FUND

This is the 113th year of the Fiske Fund. The Trustees of this Fund are Dr. Arthur Ruggles, Dr. Joseph C. O'Connell and Dr. Isaac Gerber.

On November 13, 1947, the first meeting of the year was held at the home of Dr. Gerber and it was attended by Drs. O'Connell, Gerber and Pickles. Dr. Pickles presented an account of the low income of the fund, due to the changed interest rates and the methods of investment required by the court order. There were presented copies of correspondence with Mr. Wells of the trust company and their counsel, suggesting measures that might be taken to gain relief from the existing

situation. The Trustees decided to ask the council of the Rhode Island Medical Society to assume the court proceedings, aimed at allowing investment of the funds in government bonds, where a return of 2½ per cent might be expected. This action was decided upon.

The Secretary reported the financial standing of the fund to be as follows: I shall not read it in detail. But, the fund at the moment amounts to $12,954.21.

A meeting, which was the second meeting, was held on March 18, 1948, also at Dr. Gerber's home, and this meeting was attended by Drs. Ruggles, O'Connell, Gerber and Pickles.

Dr. Gerber reported that the council of the Rhode Island Medical Society approved the proposed action of the Trustees in seeking a revision of the investment of the funds, and it was agreed to defray the cost of legal action.

During the subsequent discussion, it was brought out that the legal firm of Tillinghast, Collins and Tarrant had made a complete study of the matter for the Rhode Island Hospital Trust Company, and had already done much of the ground work.

On motion of Dr. Gerber, the secretary was directed to take legal action to bring about the desired change.

There being no further business, the meeting was adjourned.

I now present an interim report for this annual meeting. The Secretary is pleased to report that Colin Makepeace of the legal firm mentioned above has undertaken to present a petition to the Supreme Court, requesting authority to change the method of investments. It is felt that as a result of this the fund will be able to resume its normal activities during the coming year.

This report is respectfully submitted by the Secretary.

WILFRED PICKLES, M.D.

COMMITTEE ON CANCER

Cancer Control work in Rhode Island has gone on in the last year without any great change in its organization. The cancer division of the State Health Department has established cancer detection clinics at the Memorial, Newport and Rhode Island Hospitals. These clinics have been functioning now for over a year and should be able to produce some statistical reports soon, which should show their value. In addition to this, the statistical work in the department has been going on and material accumulating.

The Rhode Island Cancer Society, affiliated with the American Cancer Society, has gone forward with its program of lay publicity, and of raising of

continued on next page

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funds for cancer research for care of the indigent cancer patient, for transportation of patients to clinics, and has about completed a home for convalescent or terminal patients.

Your Chairman has been in consultation with Dr. McLaughlin and Dr. Pitts of the State Health Department and Cancer Society respectively, on several occasions in the past year. It has been apparent for some time that cancer control in Rhode Island suffers from the lack of a full time executive. The burden of carrying out details of a full-fledged cancer program is just too much for any man not on full time. This has been recognized by all of us, but it has not been until this last month that such a man has become available. We are glad to announce that Dr. Walter Batchelder has been found acceptable by Dr. McLaughlin, to head up the Division of Cancer Control of the State Health Department and will report about the first of August.

This is an important milestone in the progress of all of the three agencies concerned, — the State Health Department, the Rhode Island Cancer Society and the State Medical Society. It is felt by your committee that the time is now ripe for the Medical Society to act together with these other agencies, our part being the raising of greater interest in the cancer problem among doctors of the community. We believe that the ultimate responsibility for discovery of early cancer lies with the family doctor. Detection clinics can only set the pattern for types of examination required, and while being of great educational value to doctors as well as patients, can never cover the field of discovering cancer in its early treatable stages among all of the people in any community.

Your committee therefore proposed that a meeting be held next Fall, the date being set for a Wednesday in November. The purpose of this meeting is to arouse interest in cancer by having speakers covering the fields, of research, early diagnosis and treatment and by exhibitions to be procured from the different hospitals of the State and from the resources of the Cancer Society.

At a meeting of the committee held April 22, 1948, it was voted to approve in principle such a meeting, details to be worked out immediately. Your committee also would like to recommend that each County Society have a cancer committee made up of three members, the chairman of each of these committees to be a member of the State Cancer Committee. Meetings of the State Cancer Committee would then be held in each of the counties from time to time. It is also suggested that the State Committee send out pamphlets or articles concerning cancer from time to time, to all members of the State Society.

In conclusion, it is our hope that with a full time man in the State Health Department and with the cooperation of the Rhode Island Cancer Society and the Cancer Committee of our Society, that a cancer control program, equal to that found in any state of the Union may be evolved.

George W. Waterman, M.D., *Chairman*
Joseph O'Connell, M.D.
Linwood H. Johnson, M.D.
Henry B. Moor, M.D.
William Fain, M.D.
G. Raymond Fox, M.D.
Philip Batchelder, M.D.
James M. McCarthy, M.D.
James C. Callahan, M.D.
E. Victor Conrad, M.D.
Herman C. Pitts, M.D.

COMMITTEE ON INDUSTRIAL HEALTH

The activities during the past year of the Committee on Industrial Health consisted of:

(a) A meeting of the Committee with the Director of the Workmen's Compensation Division.

(b) A meeting with the agents representing Workmen's Compensation insurance companies of this state.

(c) A hearing before the Workmen's Compensation Law Commission.

(d) Submission of the report by the Committee adopted in general by the House of Delegates.

(e) Amendments ordered by the House of Delegates submitted to the Workmen's Compensation Law Commission.

(f) Attendance and report, A A M Industrial Health meeting at Cleveland, January, 1948.

(g) Attendance at the National Convention, American Association of Industrial Physicians and Surgeons at Boston, March and April, 1948.

(h) Two personal meetings with Dr. Carl Peterson, Chairman of the Industrial Health Council of the American Medical Association, with requests as to further activities in the state of Rhode Island along industrial health lines.



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(i) At present arranging with the Connecticut Medical Society's Industrial Health Committee for a meeting in Hartford May 27, 1948.

Stanley Sprague, M.D., *Chairman*
James P. Deery, M.D.
Arthur E. Martin, M.D.
George Conde, M.D.
Richard F. McCoart, M.D.
Robert L. Bestoso, M.D.
Edward Medoff, M.D.
Charles L. Farrell, M.D.
Thomas A. Egan, M.D.
Francis E. Hanley, M.D.

COMMITTEE ON THE LIBRARY

The Library has been most fortunate in the number of gifts it has received during the past year. Doctor Arthur H. Ruggles presented us with a book cart, thus answering a long-felt need for an easy way of moving heavy volumes. The Providence Journal Company selected our Library as one of those to which it is giving the CONGRESSIONAL QUARTERLY. Under the terms of the will of the late Anna Augusta Chapin, we received Doctor Chapin's medals, the cup presented to him on the 40th anniversary of his election as Superintendent of Health and a case of instruments given to him when he was House Physician at Bellevue Hospital in 1880.

We received books from Mrs. Jesse H. Metcalf, Doctors Russell S. Bray, William P. Buffum, Arthur E. Martin and Herbert G. Partridge, and from the Estates of Doctors Harlan P. Abbott and R. Morton Smith. Journals were given us by Doctors Irving A. Beck, Francis V. Corrigan, Frank T. Fulton, Roland Hammond, Louis I. Kramer, Helen C. Putnam, Frederic W. Ripley, and Stephen A. Welch. Gifts from libraries, hospitals, organizations, publishers, government agencies and pharmaceutical companies have added many titles to our collection.

We have made use of the facilities of the Medical Library Association Exchange for the first time and, through this clearing house for duplicates, we have been able to fill in some of the lacks in our journal runs. The Exchange enables members of the Medical Library Association to give duplicates and receive needed items with no expense other than the mailing costs of material received.

Two cartons of duplicate journals were sent to the Roscoe B. Jackson Memorial Laboratory in Bar Harbor, Maine to aid in the restoration of their library which was destroyed by fire.

The Library grows steadily. Two hundred and eighty-two books, many journals and pamphlets were added through gift, purchase and exchange. Of the books purchased, twenty-four were for the main library, eight for the Davenport Collection and one for the Gormly Collection. Two hundred and twenty-six periodicals (journals, transactions, reports, etc.) are received regularly. We have begun subscriptions to two journals — the AMERICAN JOURNAL OF MEDICINE and PSYCHOSOMATIC MEDICINE — and have renewed a former subscription to the SOUTHERN MEDICAL JOURNAL which had been allowed to lapse.

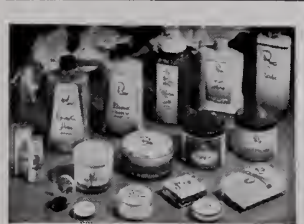
Fifty-eight journals have been converted by binding; fifty-two volumes are at the bindery now.

The volume of reference work has increased and is divided about equally between work done by the reader in the Library and telephoned requests wherein the material is called for and taken out by a member of the Society. We have had a total of 1,973 visitors; 281 of these came during evening hours. The circulation figures are: 911 journals and 224 books charged out and returned; 126 journals and 51 books out at present. These figures do not give a very clear picture of the number of volumes consulted, however, as by far the greatest number are used in the building.

We have borrowed 18 journals, 2 books and 7 pamphlets from other libraries through Interlibrary Loan. We have loaned 154 journals and 24 books.

The increase in the number of volumes during the past few years has made it necessary to move nearly every book and journal in the building. We have started this project and hope to finish reorganizing the first floor stacks this spring. 23,611 volumes have been catalogued to date.

Russell S. Bray, M.D., *Chairman*
Herbert G. Partridge, M.D.
Herbert E. Harris, M.D.
Robert T. Henry, M.D.
Paul Appleton, M.D.
Whitman Merrill, M.D.
Paul C. Cook, M.D.
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COMMITTEE ON MATERNAL HEALTH

The Committee for the study of Maternal Deaths of the State's Society submits the following report.

For the year 1947 there were 16 maternal deaths due to obstetrical causes in the State of Rhode Island. This number of deaths occurred in 18,498 cases. These figures were supplied by the State Board of Health to the Committee.

These deaths have not been investigated by the Obstetrician employed for this purpose by the Department of Health who in previous years has cooperated with the Committee in supplying this investigator.

We have the assurance of Dr. Francis V. Corrigan of the State Board of Health that more active investigation will be resumed this year.

John G. Walsh, M.D., *Chairman*
Michael H. Sullivan, M.D.
George E. Bowles, M.D.
Alfred L. Potter, M.D.
John F. Murphy, M.D.
Richard H. Dowling, M.D.

COMMITTEE ON MEDICAL DEFENSE AND GRIEVANCE

This committee has been moderately active throughout the year and several cases have been submitted for discussion and recommendation. In one case, settlement was advised and in another case, where the charge was obviously unjust, the committee recommended that the suit be defended in Court. The verdict resulted in a non-suit and unless the decision is appealed to the Supreme Court, the result may be considered as a victory for the physician and the entire medical profession. The committee is never inactive and cases are constantly being brought to our attention. In some cases the matter is easily disposed of and it is only rarely that serious discussion is required of the entire membership. At this time, the committee wishes to emphasize that physicians should report promptly any case where a patient seems likely by his attitude to resort to legal measures for adjustment of a dispute or dissatisfaction with treatment even if the case has not been referred to a lawyer.

Roland Hammond, M.D., *Chairman*
Norman S. Garrison, M.D.
John E. Ruisi, M.D.
Fenwick G. Taggart, M.D.
James L. Wheaton, M.D.
Robert H. Whitmarsh, M.D.
John F. Kenney, M.D.

COMMITTEE ON TUBERCULOSIS

Your Committee has continued to work on the problems of tuberculosis control. A plan for tuberculosis control in the hospitals of Rhode Island was drawn up and sent to the various hospitals in the State. A copy of this was published in a previous issue of the Journal. A follow-up letter is to be sent annually to these hospitals with a form to be filled out, indicating what procedures are used and what results are obtained.

Because of the shortage of tuberculosis beds and the consequent long waiting lists for patients seeking treatment for tuberculosis, a sub-committee was formed to study conditions at Wallum Lake Sanatorium. It was the hope that they might be able to find some means by which more patients could be handled. After their visit to the Sanatorium, it was felt that everything within reason was being done, that the shortage of beds was a result of difficulty in hiring and keeping personnel at the Sanatorium. It appeared that the only means of immediate improvement would be to cut down the stay of the Sanatorium patients to the minimal period compatible with adequate care.

The Committee is of the opinion that to further promote interest and understanding of tuberculosis



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problems, it would be advisable for the various county medical societies to appoint tuberculosis committees for the purpose of studying and handling local problems.

The matter of tuberculosis control amongst school teachers has been discussed, and the Committee is of the opinion that it would be advisable to have chest plates of all teachers annually. Further, it would seem advisable to have annual x-rays of all school employees, especially those who come in close contact with pupils. A definite program for this procedure has not yet been worked out.

The Eastern Section of the American Trudeau Society has been inactive during the War years. The officers of the Section are interested in carrying out a program that will be helpful to the localities covered by this Section and has requested recommendations from the various states. In discussing this matter, the Committee felt that the Section would serve a more useful purpose if it were not so large, if there were a New England Section to represent this particular region, and that it might combine with other local groups interested in tuberculosis in order to prevent a certain amount of repetition and to provide a more unified program. It was suggested that the Eastern Section might draw up a list of speakers who could be called upon to give talks to local societies on various aspects of tuberculosis. These recommendations will be presented at the forthcoming meeting of the Eastern Section of the American Trudeau Society.

John C. Ham, M.D., *Chairman*
Royal C. Hudson, M.D.
Daniel A. Smith, M.D.
Philip Batchelder, M.D.
Lewis I. Kramer, M.D.
Charles L. Southey, M.D.
Peter F. Harrington, M.D.
U. E. Zambarano, M.D.
James P. Deery, M.D.

COMMITTEE ON WATER POLLUTION

This year the committee has no intensive work on their part to report. As you know the campaign started by us resulted successfully and the referendum for financing the installation of a sewer project in the Blackstone Valley was passed and governmental steps to get this under way have already been taken. Last summer a larger area of the bay was closed to bathing and the taking of shellfish. A state pollution abatement committee has been active and Drs. Chase and Farrell of our own committee have been members of that. Besides this, the General Assembly have authorized a number of communities to issue bonds for

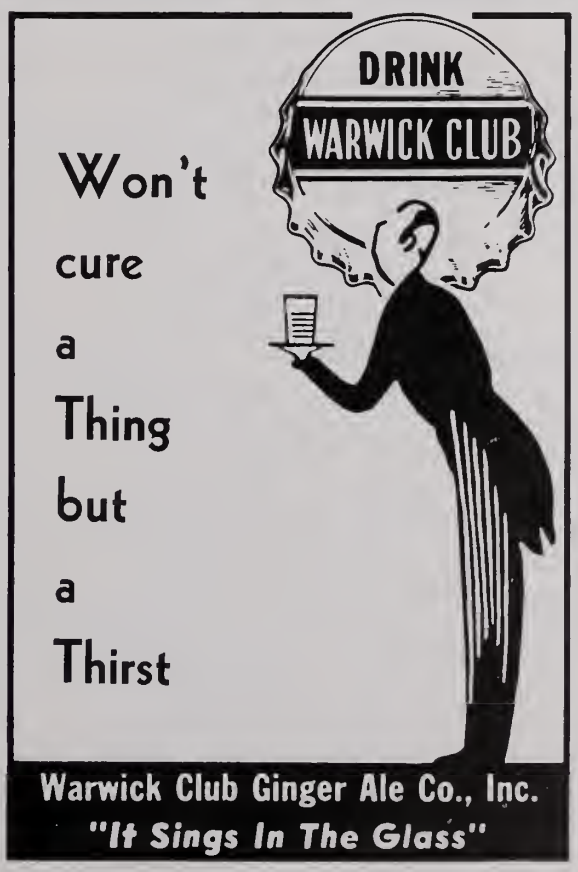
continued on page 467

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COMMITTEE ON WATER POLLUTION

concluded from page 465

sewage work. At the present time everything seems to be progressing satisfactorily and we will continue to cooperate with the state abatement committee.

Peter P. Chase, M.D., *Chairman*
Edward S. Cameron, M.D.
Anthony V. Migliaccio, M.D.
Paul C. Cook, M.D.
Charles L. Farrell, M.D.

INDEX OF ADVERTISERS

	PAGE
Abbott Laboratories	449
Alkalol Company	462
American Meat Institute	414
Ames Company, Inc.	450
E. P. Anthony, Inc.	436
Ar-Ex Cosmetics, Inc.	463
Arlington Chemical Company	417
Ayerst, McKenna & Harrison	421
Bayview Convalescent Home	436
Blanding & Blanding	426
Borden Company	425
J. E. Brennan & Company	450
George A. Breon and Company	451
Joseph Brown Company	461
Butterfield Drug Stores	460
Camel	424
S. H. Camp Company	420
Ciba Pharmaceutical Products, Inc.	413, 447
Curran & Burton	460
Edgewood School	464
J. E. Hanger, Inc.	461
H. P. Hood & Sons	Inside Front Cover
Eli Lilly & Company	Insert Between 426-427
McCaffrey, Inc.	461
S. E. Massengill Company	422
Mead Johnson & Company	Back Cover
Medical Milk Commission	443
Meredith & Clarke, Inc.	459
A. B. Munroe Dairy	451
Mutual Benefit Health and Accident Assn.	468
Neland Pharmaceuticals, Inc.	460
Parke Davis & Company	Inside Back Cover
Philip Morris & Company	457
Physicians Directory	466-467
R. I. Limb Company	465
Schering Corporation	455
G. D. Searle & Company	445
Sharpe & Dohme, Inc.	453
Smith-Holden, Inc.	416
E. R. Squibb & Sons	415
Strand Optical Company	436
Tilden-Thurber	458
U. S. Vitamin Corporation	Insert between 418-419
Upjohn Company	423
Warwick Club Beverages	465
White Rock Bottling Co. of Rhode Island	448
Winthrop-Stearns, Inc.	418

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CHARLES V. CHAPIN ORATION

"INDUSTRIAL HEALTH"

See Page 483

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Volume XXXI, No. 8

Contents Page 475

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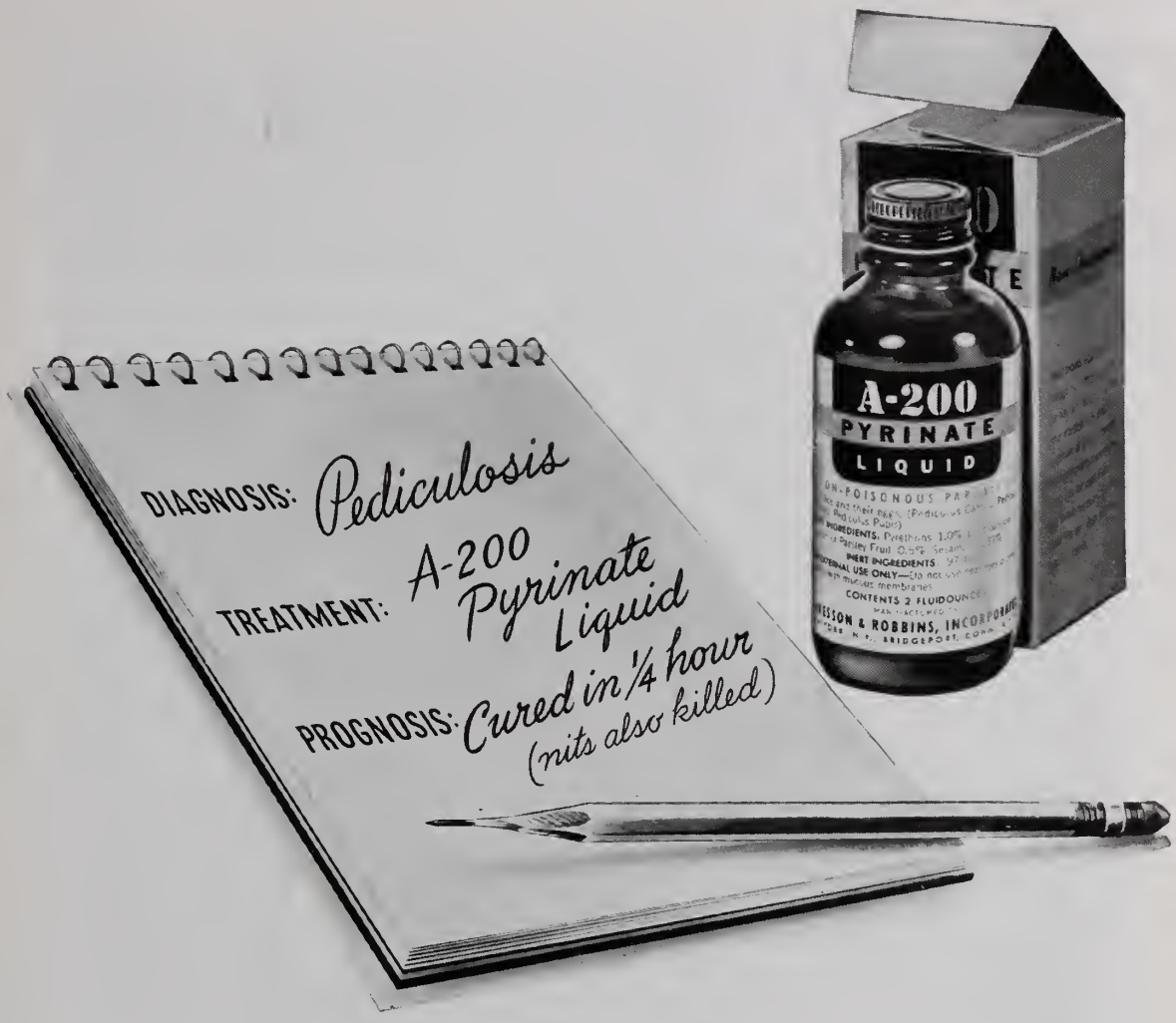
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Vol. XXXI, No. 8 August, 1948

TABLE OF CONTENTS

PAGE

Industrial Health, (The Seventh Annual Charles V. Chapin Oration)
Philip Drinker 483

Continuous Lumbar Peridural Anesthesia in Obstetrics,
Howard W. Umstead, M.D. *and Walter J. Dufresne,* M.D. 489

The General Practioner in New England Hospitals,
A Report to the Council of the New England State Medical Societies 498

Rhode Island Medicine, Its Problems and Its Solutions,
Articles prepared by the Committee on Public Policy and
Relations of the Rhode Island Medical Society 512

EDITORIALS

Observation and Diagnosis 494

Medical Teachers 495

Seal of Approval 495

The C. V. Chapin Fellowship 496

The Fiske Fund 496

MISCELLANEOUS

Additional Participating Physicians, The Rhode Island Plan 493

Book Review 532

Index of Advertisers 532

Medical Library Notes 530

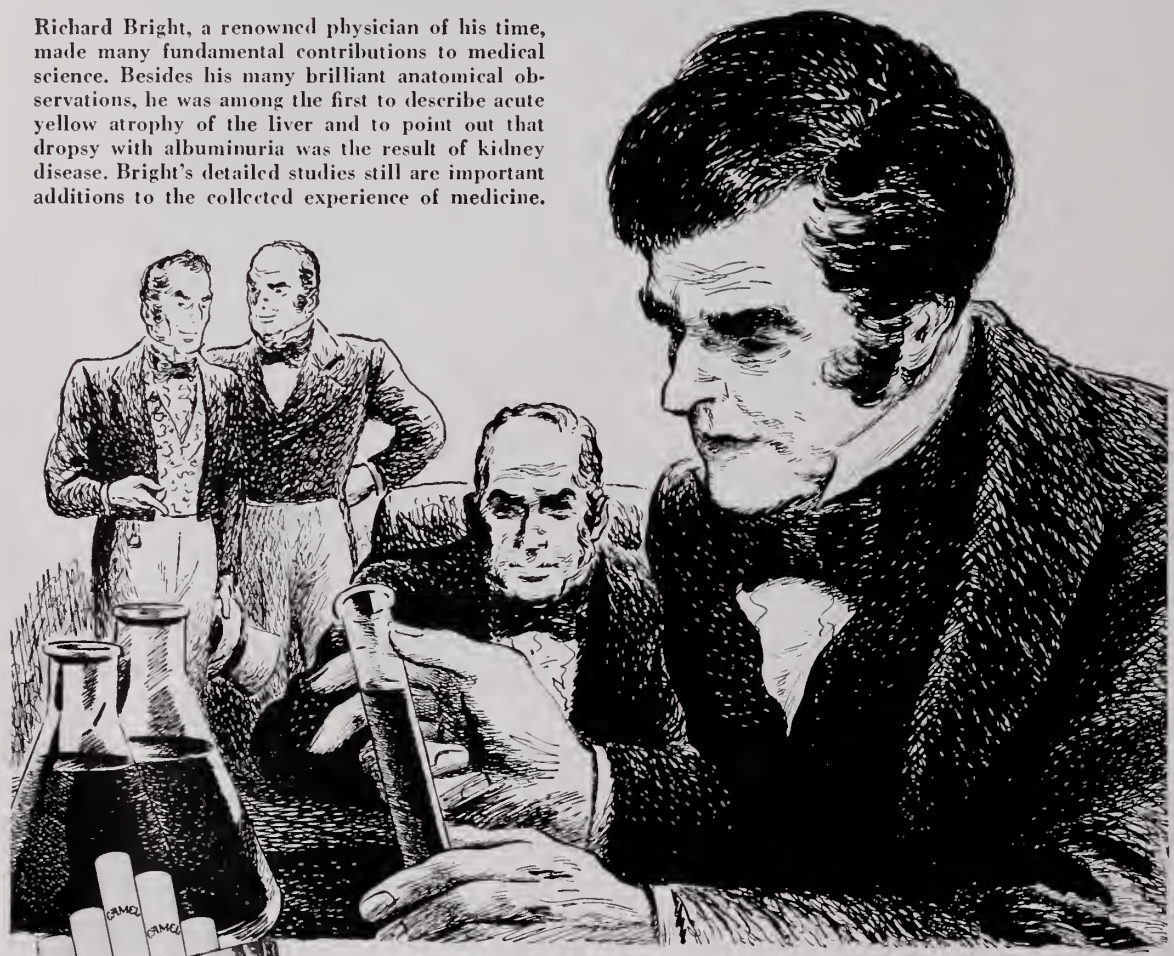
Minute Adopted by Board of Trustees of Butler Hospital on the
Retirement of Dr. Arthur H. Ruggles 492

Woman's Auxiliary 529

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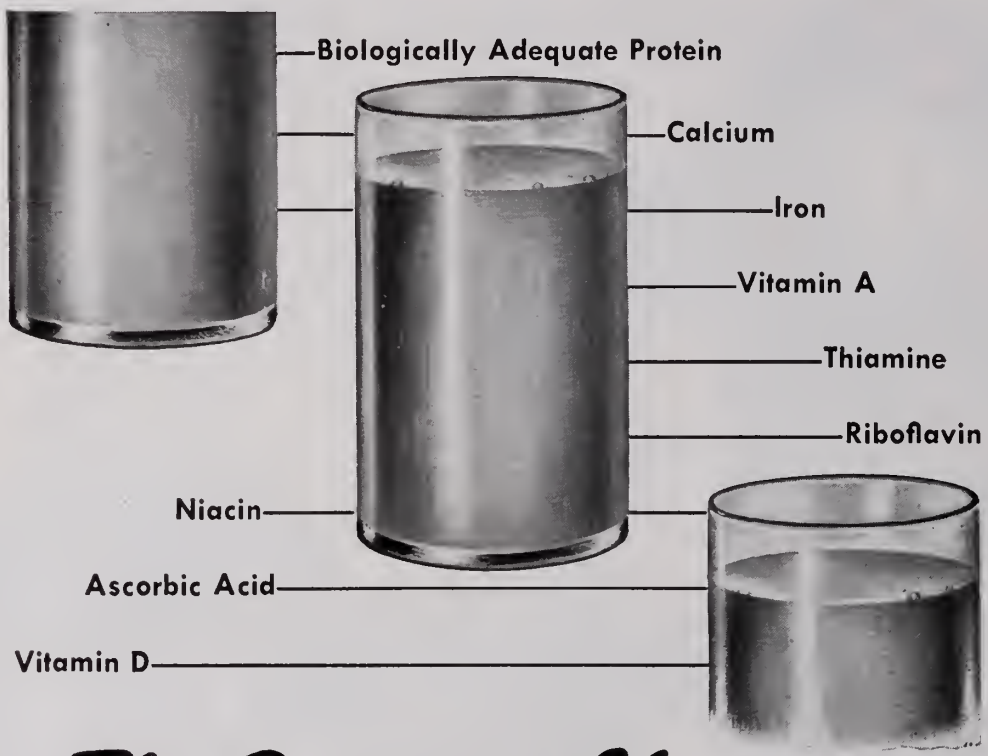
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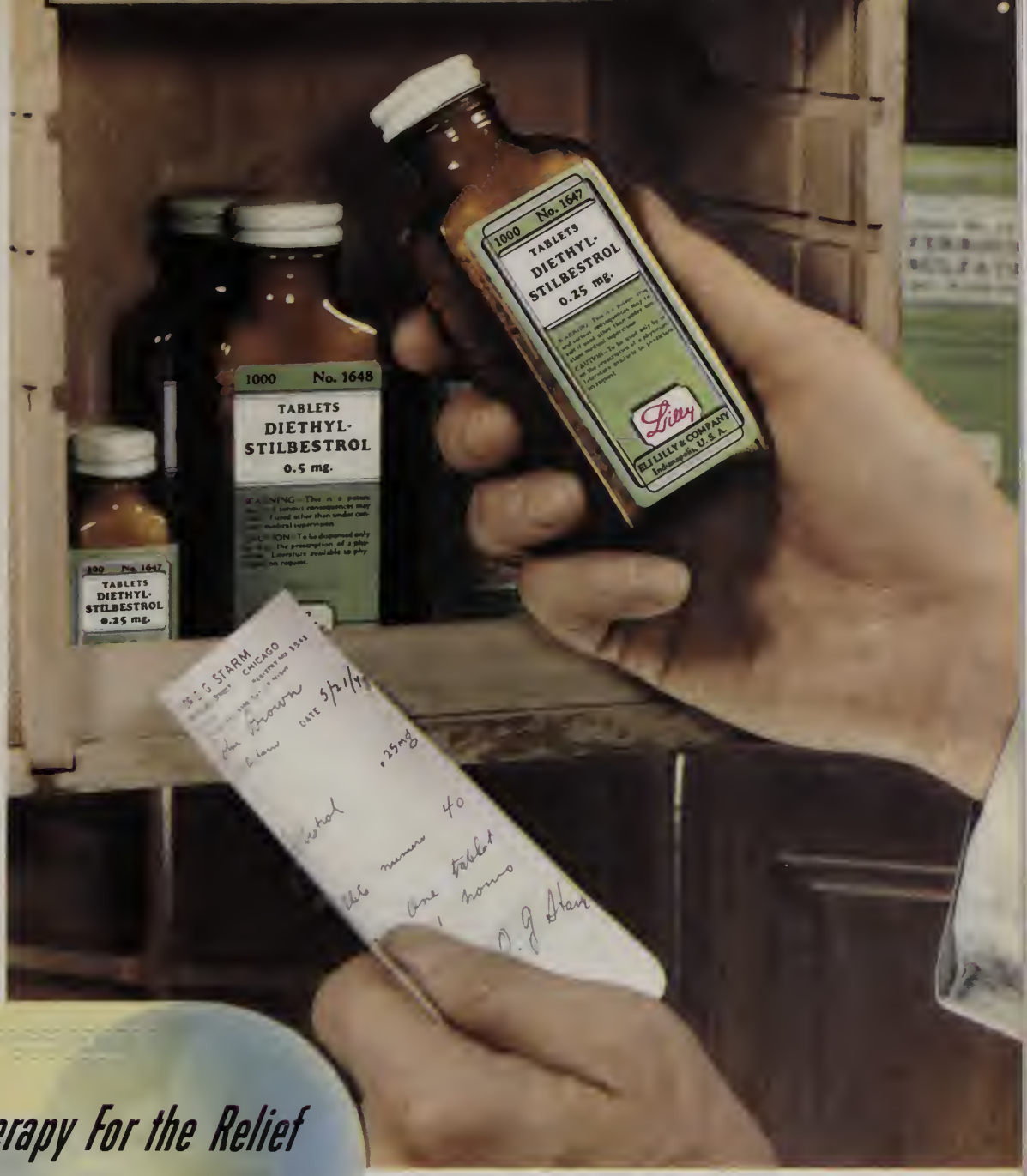
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Lilly in Switzerland

OF ALL of the admirable qualities of the Swiss people, unselfish, humanitarian service is characteristic. It was a Swiss, Jean Henri Dunant, who founded the Red Cross. The executive committee, known as the International Red Cross Committee, is made up entirely of Swiss citizens. Similar organizations doing private relief work for unfortunates all over the world have their headquarters in Switzerland and are stanchly supported by the Swiss people.

Although Lilly products had been sold in Switzerland for many years, it was not until 1947 that the first Lilly representative was appointed. Those engaged in medical research are now contacted regularly. It is hoped that Eli Lilly and Company will be accorded the privilege of co-operating in the development of discoveries certain to come from the laboratories of Swiss scientists. To make available to all the findings of the world's best medical talent is the goal of Eli Lilly and Company.

LILLY INTERNATIONAL

The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXI AUGUST, 1948 No. 8

THE SEVENTH ANNUAL CHARLES V. CHAPIN ORATION*

INDUSTRIAL HEALTH

PHILIP DRINKER

The Author. *Philip Drinker, of Boston, Massachusetts. Professor of Industrial Hygiene, Harvard School of Public Health.*

THE NAME of Charles V. Chapin is held in high esteem by all engaged in public health work. It is unusual for a physician to have such a keen understanding of the technical problems in public health engineering as Dr. Chapin possessed. His crusades for improvement in all branches of sanitation benefited us all for he practiced his profession all over the nation. We, at the Harvard School of Public Health, are proud of our small share in this eminent physician's memory. He served for some years on our Faculty and helped us start our School.

I would like to present to you this afternoon a review of some of the industrial health problems which have arisen over the last 50 years. I speak from professional experience over only the last 25. Some of these things have to do with prevention of illness and others are concerned with management and care of the disabled.

Gaseous Impurities in Air

Any job which exposes the worker to adverse conditions is apt to cause disability. The most frequent adverse effect is probably that from breathing air of abnormal composition. The reaction of individuals to various atmospheric impurities varies surprisingly but there is usually no difficulty in setting limits which are safe and defining also those which are lethal. The commonest abnormality in ordinary air is reduction in the normal oxygen pressure. Frequently this change is accompanied by the addition of carbon monoxide. Atmospheres high in nitrogen, and therefore low in oxygen, are found in mines and often on the surface where vegetation has decayed. After fires oxygen concentrations may be low and are accompanied by excess carbon monoxide. These two, low oxygen and dangerous carbon monoxide, are the leading causes of death from so-called gas poisoning.

Deaths from illuminating gas poisoning in our large cities are always reduced when the carbon monoxide concentration of the gas is reduced. Natural gas contains no carbon monoxide and presents no risk except that of fire. Most of those killed in the Cocoanut Grove disaster in Boston or the Hotel La Salle in Chicago were gassed first with carbon monoxide. Many of the victims in fires are not burned at all. Accounts of the fire raid in Hamburg, and later of Japanese cities indicate that CO gassing caused more casualties than did explosives[1].

All of the major chemical and oil producers are developing new organic solvents of undetermined toxicity. Vapors from organic solvents generally are toxic or inflammable, or both. Naturally, industry prefers to use those which offer the least risk, like acetone and ethyl alcohol, but toxic solvents like carbon disulfide, carbon tetrachloride, and benzol have uses which make them important industrially, even though they are toxic.

A colleague of mine had two patients recently from a large chemical firm with an excellent safety department and an alert management. These men were cleaning the grease off a large piece of machinery and were using a gasoline type of solvent. The safety engineer found the air in the working area was close to the inflammable limit, so ordered the addition of carbon tetrachloride, an excellent grease solvent, to reduce the fire risk. It accomplished the purpose but made one of the men desperately ill with acute liver poisoning[2]. In retrospect we could attend to the degreasing in better fashion but I, for one, would not scold the safety man too much, and neither would anyone else who has seen the results of an explosion in a crowded factory.

continued on next page

* Presented at the 137th Annual Meeting of the Rhode Island Medical Society, at Providence, on May 12, 1948.

Some of the new chemicals pose serious questions as to carcinogenicity, severe dermatitis, and possible toxicity via vapor inhalation. The physician wants to make sure that exposures are safely below the danger point, so he charges the engineer with the job of maintaining safe exposure levels. The engineer promptly asks what is a safe concentration so he can build the equipment to maintain it. Generally the safe limits are not at all precise, and more properly are a range or zone below which man is safe for an ordinary working day. For instance, carbon monoxide concentrations in vehicular tunnels are kept low enough for the tunnel guard, who is on an eight-hour shift in the tunnel.

The discussion as to what range is toxic and what is safe can become acrimonious, depending on the interests represented. I was once called in by a large insurance company whose clerical help in their mimeographing room became sick when the inking apparatus was cleaned with a certain solvent. The firm that sold the solvent objected violently when we set a ventilation figure so low it was cheaper to use a different solvent. It was maintained — and correctly — that the original solvent only made a few people ill, so why should we be so fussy.

Compressed Air Illness

Deep diving and caisson work have been practiced for years. They have always been risky; the pay is high and the hours of work are short. The risks are the immediate ones of drowning, if the air pressure fails, and of compressed air illness, if one is brought too quickly from the high pressure to normal.

The diver is encased in a rubberized suit which is inflated to the pressure of the water surrounding him. The sand hog working in a subaquaeous tunnel is protected from water seeping in, by means of compressed air. The diver can descend as rapidly as his buoyancy or the landing stage will allow. The tunnel worker reaches his high pressure by way of an air lock which can be inflated very rapidly. There is no adverse effect on man from these quick inflations, if one's ear passages are clear. But one cannot return quickly to normal pressure after long exposure to high pressures without danger of compressed air illness. Bubbles of nitrogen form in the body tissue and exert pressure on the nerves causing severe pain.

A hundred years ago divers were decompressed gradually and slowly. Then, in 1908, J. S. Haldane[3] showed that it was better and vastly quicker to drop the total or absolute pressure to half the original and then go the rest of the way in steps. In 1937 Behnke and Shaw[4], working at our school, revived and improved upon earlier theories of giving oxygen to divers who were being decompressed. Such oxygen inhalation has proved to be most important in the prevention and treatment of compressed air illness.

In 1925 at the suggestion of J. H. Hildebrand of the Bureau of Mines, Sayers, Yant, and Hildebrand made some trials of mixtures of helium and oxygen for possible use in deep diving[5]. Their results indicated that it might be possible, with helium, to dive to greater depths with faster decompression than was possible with ordinary compressed air. Hildebrand's hope for improvement by using helium was based on the fact that nitrogen, which causes the trouble, diffuses more slowly than does helium. Gases diffuse at rates inversely proportional to their molecular weights which are 28 for nitrogen and 4 for helium. On that basis, hydrogen, with a molecular weight of 2, would be still better, but its inflammability precludes its use in breathing mixtures.

The Navy investigated this possible use of helium and was ready to try it on practical diving tests when the submarine Squalus sank in 240 feet of water off Portsmouth, New Hampshire, in 1939. The Navy's best diving team flew to the scene of the disaster, rescued the survivors by means of the Navy's diving bell and then salvaged the vessel after months of superb diving[6]. Their safety record, incidentally, was phenomenal.

It is not beyond the realm of practical engineering for man to drive subaqueous tunnels at greater depth and under greater pressures than any heretofore attempted. It would be possible to operate the tunnel under compressed air, as heretofore. The men, however, would breathe oxy-helium mixtures from breathing bags or tanks carried on the back. The breathing mixture would be replenished from a pipe line within the working area. Such an arrangement would be no more fantastic than some of the things we do in industry today. Remember that working codes now allow a man at high pressures only two shifts of a half hour each. This is his full working day. Anything which will lengthen the possible working period and permit working at greater depths is hopeful for future improvements.

Dust Diseases

In 1920 silicosis was a serious problem in industry. Its significance was not fully appreciated by physicians and it was often ignored or belittled by management. Labor's attitude was rather apathetic because the disease is slow in making itself apparent. Today silicosis is definitely under control, because it is understood. The etiology is well defined and the frequency is gradually lessening.

The improvement is due to dust control and to a full realization of the concomitant effects of pulmonary tuberculosis. Further improvements

will probably parallel reduction in the general incidence of tuberculosis. We have, however, important mining areas in which we have done about all we know how to do, yet we have not eliminated the disease. We claim, nevertheless, that a young man can now become a miner or a stonecutter and go through a normal working life without getting silicosis.

In 1929 the granite producers in New England sponsored a study in our laboratory of dust control in granite cutting. We installed a miniature granite shed with tools operated by a skilled workman supplied by the Union. We soon developed specifications for the control of dust[7] and have seen them expanded and adopted by both employers and employees.

The drilling and blasting of hard rock in mines has been the major cause of silicosis all over the world. The term, "hard rock", is used designedly, for it implies rock high in quartz, the chief etiological agent in producing silicosis. Today hard rock is drilled wet — a stream of water runs through the shaft of the drill and wets the dust as it is generated. The fact that the water keeps the point of the drill cool and thus helps keep its temper is an added incentive to wet drilling. Also, mines are ventilated under rules which help greatly in supplying the miners with clean air. The combination of wet drilling and ventilation is an effective preventive for silicosis.

1. *Aluminum therapy:*

It was shown on experimental animals that the inhalation of traces of freshly ground aluminum dust[8] mixed with quartz greatly lessened the potency of the latter. The results were so promising it was advisable to try such prophylactic treatment on man — an experiment now in progress in several different places. The intent is to prevent the formation of fibrotic nodules in the lung area, rather than to modify any existing lesions — that is, the method is prophylactic and not therapeutic although there was a suggestion of therapy in the original plan. Treatment is not supposed to be given unless reasonable dust control has been installed.

It might be pointed out that no treatment for silicosis has ever been devised and none is likely. The workman is diagnosed as being silicotic when his x-ray picture is clearly abnormal. Often it does not take an expert to make the diagnosis. At that point medical science cannot do much for the man except remove him from further dust exposure and try to prevent him from acquiring tuberculosis Therefore, if workmen demand that this aluminum prophylaxis be thoroughly explored their attitude is understandable.

2. *Shaver's disease:*

A brand new industrial disease was described recently by Shaver and Riddell[9], who observed spontaneous pneumothoraces in men exposed to fumes from high temperature electric furnaces in which aluminum oxide, as the mineral bauxite, was melted and fused with coke. The resulting fume consisted essentially in alumina, Al_2O_3 and silica, SiO_2 in the approximate proportions of 50 to 40[10]. The plant they described had been running for some years but, during the war, was pressed hard to turn out more material so that the ventilation was overtaxed and became inadequate. Until then no trouble had been experienced, or at least it had passed unnoticed.

The etiology of the disease, appropriately named after Shaver, who first described it, is undetermined and may easily remain so as it is reported that plant changes have eliminated the air pollution. The condition produced was serious to 35 workers and fatal to 7 out of 344 individuals exposed. The size of the particles in the fume was of the order of a fraction of a micron, measurable only by electron microscope. We have no data at all on the effects of breathing such finely divided fume particles. All of the past exposures to silica have been from dusts created by processes such as stone cutting, rock drilling or crushing. Alumina, Al_2O_3, has never been known to cause anything remotely resembling the condition described.

Gardner[11] showed that quartz dust above 3 microns was unlikely to cause any fibrosis We[12] extended this study down to 0.6 micron dusts and found the potency to increase markedly as particle size decreased. Hatch and Kindsvatter[13] exposed animals to ground silica dust averaging 0.18 microns in size and produced even more severe lesions, showing that maximum potency had not been reached.

Recently there has been introduced commercially a number of different kinds of finely divided silica made by chemical processes such that the ultimate particle size is still smaller. The results of potency tests have yet to be published. Until they are, industry probably will look upon this silica as very toxic and handle it with proper precautions. There seems to be unanimity in expecting considerable industrial use for it.

3. *Beryllium poisoning:*

In 1943 Hyslop[14] and others published a paper indicating that the metal beryllium, of itself, was not toxic and that toxic effects from use of beryllium in its various compounds or alloys was due to acid radicals in beryllium compounds or to hydrolysis of the beryllium salts. Unfortunately this optimistic forecast was expanded somewhat beyond the implications of the authors, which were none too

continued on next page

clear, and beryllium compounds were used in the fluorescent lamp industry with no special precautions. A series of extremely severe poisonings and numerous deaths occured[15] and others are now being reported from plants processing beryllium ores.

The largest use for beryllium is by atomic energy plants, as it serves a purpose in the atomic piles for which there is no present substitute. These plants and some of their sub-contractors for the Atomic Energy Commission have had fatalities and serious beryllium poisonings from processing beryllium ore and from machining, grinding and polishing to pure metal.

Beryllium is the lightest metal known and imparts to copper properties which go to make up a spring of great strength and of considerable industrial promise. It is also used in alloys for non-sparking tools. Companies engaged in making such alloys claimed that there had been no ill effects from the beryllium so used but this claim has been refuted, as typical fatal poisonings have been reported.

The disabilities which occurred in the fluorescent lamp industry in our own state of Massachusetts caused what Hardy and Tabershaw[15] described as a delayed chemical pneumonitis. Some of the patients died and, at autopsy, showed lung and liver lesions which pathologists considered to bear resemblance to sarcoid for which the condition was at first mistaken.

At the present time the etiology of these poisonings is still obscure but there is no question at all that beryllium compounds must be handled with extreme caution.

4. *Lead poisoning:*

Another classical industrial disease, lead poisoning, is becoming a rarity. It has been shown that it can generally be forecast, and thus prevented, by routine urinalyses. Normal urinary lead is below 0.2 milligrams per liter[16] so that consistent excretion of lead much in excess of the normal is viewed with suspicion. The patient can generally be moved to a less dusty job before his lead absorption reaches clinically significant levels.

This optimistic state of affairs does not mean we no longer have lead poisoning. It means that we can and do prevent it, yet we continue to use lead in vast quantities

5. *Metal fume fever:*

Another industrial disease, metal fume fever, poses some unsolved problems which are reminded of the complexities introduced by the exposure to submicroscopic fume particles in Shaver's disease. It has been known for many years that the breathing of dense clouds of freshly formed zinc oxide caused a transient febrile reaction which is incapacitating for about a day.[17] The body temperature can rise to as much as 104°F. and is accompanied by a leukocytosis which persists for some hours after the temperature has subsided to normal. While the white cell count remains high, one enjoys a resistance to a second attack of the fever and can inhale, with impunity, an amount of zinc oxide which ordinarily causes a sharp temperature rise.[18] Metals other than zinc can be burned to the oxides which, in turn, can produce reactions somewhat like those from zinc oxide, but the reactions may be of very different severity. For example, freshly burned magnesium oxide[19] has negligible effect, while cadmium oxide can produce a fatal reaction.[20]

But one fails to induce metal fume fever from zinc oxide taken from the commercial package and blown into the air. Similarly, cadmium oxide fumes from freshly burned cadmium are dangerous, yet men handle safely this identical cadmium oxide once it has been collected.[21] There is no chemical difference between the freshly formed zinc oxide and that which is taken from the chemical package. The freshly formed oxide disperses nicely in air and forms a cloud which disseminates uniformly throughout any confined space. The material from a package flocs and is hard to disperse, save in liquid media such as a paint vehicle. Men who tend zinc furnaces know perfectly well what metal fume fever is and do not pay much attention to it. They know how to avoid it and know its effects are not cumulative. Those who handle the collected powder seemingly do not get metal fume fever although they breathe concentrations in excess of those breathed by the furnace men.

Industrial Uses of X-rays and of Atomic Energy

The atomic era has ushered in a new set of public health problems which are very troublesome It is common practice to take roentgenograms by radium or by x-ray of metallic castings in order to detect defects. Fluoroscopic inspection of parts passing along on a belt may be required in manufacturing specifications. Adequate safety rules have been developed, but intelligent enforcement is far from perfect.

Fluroscopes are used by shoe stores under conditions which roentgenologists would scarcely approve. You may remember that in 1943 we had a disastrous series of x-ray burns in a shipyard dispensary when unauthorized persons repeatedly stuck their hands into a fluoroscope for the amusement of themselves and their friends.

The estimation and control of exposure to radioactive substances, called health physics, is now well organized. We hope it belongs properly to the field of industrial hygiene. The impetus for the rapid

development of this science was, of course, the atomic bomb project. The scientists who planned and carried out the construction and operation of our atomic energy plants had a very full appreciation of the serious health risks involved and took more than what industry calls legally *all reasonable precautions*. With other engineers, I had the privilege of visiting these plants recently and studying their records with view to helping them plan their peace-time control of the health risks resulting from nuclear fission. We were greatly impressed by the fact that their large plants at Oak Ridge, Tennessee and Hanford, Washington, attained a remarkable safety record. Their industrial medical and their safety setups were elaborate and expensive, but their results were so much better than anything we, supposedly experts in this field, had expected to see, it made us revise our ideas on preventive work. You will appreciate the fact that the individual companies, like DuPont, Eastman, and Stone and Webster took the contracts to build and operate these plants with the proviso that they be allowed to do what they thought was reasonable to make conditions safe. Admittedly, expense was not spared, and some money was wasted, but the proof that nuclear energy can be utilized safely was established.

Unsolved are some of the pollution problems which you can find outlined in the Smyth[22] and Baruch[23] reports, both of which should be required reading. Some of the gases from the stacks carry radioactive gases and particulate impurities. Water from the laundries which clean "hot clothing" becomes contaminated. Machinery, tool steel, and building materials become too hot to handle. What is to be done with these wastes? It is no secret that atomic power will be with us before so many years, so that a practical solution of these difficulties cannot be postponed.

Labor Relations and Health

There is no question at all that establishment of the Coal Miners Welfare Fund by John L. Lewis raised the preplacement and the checkup physical examinations to the level of respectability in union circles. In a large smelter with which I am connected, the striking workmen arranged in advance with management for the men to leave the picket line to enter the plant and have their routine medical examination. This occurred in 1947 on the west coast, not far from a shipbuilding area, where in 1944, the Maritime Commission, Navy, and Public Health Service, acting as a team, were prevented by the dominating union from giving checkup examinations and chest x-rays to a group of welders. I was in charge of the shipyard health work and that experience rankled sorely, for we had been promised cooperation by union headquarters in Washington. It turned out that the local union official responsible for keeping us out had witnessed a stupid abuse of x-ray examination in a plant in Massachusetts some years before and he had not forgotten the event.

The establishment of workers' clinics, as by the Union Health Center of the garment workers in New York and the Labor Health Institute in St. Louis, has done much to show the workman what he has to gain from good medicine and good public health practice. Such clinics are prepaid medical schemes, but they are logical; they are economically sound, and they work.

Industry is greatly concerned with absenteeism. It wants the man to have medical advice that will get him back to work and on the payroll. The illnesses and accidents which come into a busy industrial clinic in a large factory are not much different from those which come to the Out-Patient Department of a busy city hospital. Why not handle them in exactly the same way the hospital would, by treating them right there and referring to specialists those you would refer in ordinary practice? This means the industrial doctor becomes a general practitioner and steals some of the patients from the local general practitioner.

When a worker comes to the plant physician and asks him if he won't call at his house to see his wife or child, management knows that the physician has the respect of the worker. This is precisely what is needed. Management would like the doctor to be completely free to practice medicine and not to bother whether the patient's condition is the result of his job or not. Industry needs good medical practice and it can offer some attractive inducements. It will pay decent salaries and make conditions pleasant. To the physician who looks askance at industrial practice we would point out that we have about 60,000,000 workers in the United States, and some 10 or 15 million of them came out of the armed forces where public medical care was practiced very effectively. It is unlikely that these men and women will tolerate anything less good than they had in the Services.

I doubt if there is a good hospital in the country, certainly no teaching hospital, that does not need new income and need it badly. Industry wants good medicine and does not want it free. There is nothing but an outmoded tradition which prevents hospitals and clinics from approaching industry and offering to help in the management of their medical and surgical problems. Industry would expect to pay for such service. You would get an especially favorable reaction from insurance companies and compensation boards if your hospitals would offer to contract to help them with their rehabilitation of the injured and of the maladjusted worker.

continued on next page

Workmen's Compensation and Health

It is a regrettable fact that the most effective stimulus which one can apply to the employer who refuses to recognize a health or accident hazard is an expensive damage suit. Admittedly, litigation is not a good way to settle an argument, but a lawsuit undeniably has a salutary effect.

In most states industrial accidents and diseases are compensable and the suit is heard before a commission and not before a judge and jury. This means that eloquence and oratory give place to a terse presentation of the facts, which include the clinical and surgical findings, as well as a good case history — an account of the working conditions. By and large the employer does better under the compensation law than at common law, and damages can be guessed pretty accurately in the event of an adverse decision. The net result is that the worker gets his award promptly and without expensive lawyers' fees if his claim has any merit at all.

There are several industrially important states, such as Ohio and Washington, where compensation insurance is a state monopoly. Others, like New York and California, allow private companies to compete with the state funds. Still others, like Massachusetts, have no state fund and all compensation insurance is carried by private insurance companies, or the employers are self insured, with state license.

From my own experience in dealing with these problems, I believe the competition engendered by having the state fund and private companies compete is a good thing — if the competition is kept on a fair basis. State monopolies become too powerful and the people suffer, just as they suffer from the improper abuse of power by any other group. Also, the monopolistic funds, in my opinion, can become bureaucratic, inefficient and expensive, for there is no one forcing them to keep down their costs.

In compensation suits industry is often inflicted with testimony from reputable doctors who are completely without industrial experience. A statement from a patient that he works in such and such a plant is enough to elicit a diagnosis so colored that the case can be construed only as one of industrial poisoning. The doctor cannot very well be expected to go and see what all his patients do, so he guesses at the job from the patient's description of it. This kind of thing got badly out of hand in about 1930 when there were a great many suits, all over the east, for silicosis. Some of the country's most eminent radiologists, like Pancoast in Philadelphia, then got their colleagues to agree that a reliable history of exposure to free silica dust was essential to the making of a diagnosis of silicosis.

Today no good radiologist will venture such a diagnosis without a history of heavy exposure to silica dust. We, who work with the industry, would be grateful if all doctors would be as careful in getting the workman's history.

If a workman develops a hernia he is apt to go before the Compensation Board and state that he first became aware of his injury while performing some task in the factory at some definite time. If he does he is virtually certain to be paid compensation for his loss of time and for the cost of the surgery necessary. This implies that hernias are solely industrial in origin — something nobody thinks is true.

If an employee becomes partly incapacitated from heart trouble, is given an easy job such as operating an elevator, and dies one night while at home it may or may not be considered occupational — the decision is unpredictable. But if the cardiac patient dies while he is on the plant premises most state Commissions would hold that the death should be charged to industry.

Such decisions are not good for labor relations and they create a distrust of medicine in the eyes of both employer and employee. We wish good physicians would not be so reluctant to go to court and testify in these compensation cases. The ordeal is not a severe one, the reputable physician commands respect, and his considered opinion is heeded.

Many of our states have occupational disease laws under which compensation is limited to a schedule of industrial diseases like lead poisoning or silicosis. When something new comes along like Shaver's disease or beryllium poisoning, redress has to come via common law. There is nothing worse for labor relations than such needless damage suits. Defeat rankles, no matter who is the loser. In its wisdom the Supreme Court of Massachusetts declared that silicosis should be compensated as an accident because it is traumatic. This decision has saved us a lot of trouble, as any new industrial disease can be handled very satisfactorily by the State Industrial Accident Board. Nobody but the etymological purists care two cents whether silicosis is traumatic or not — an amusing state of affairs, but not an unjust one.

Wisconsin compensates for any disease arising out of, or in the course of employment, but most states stick to the scheduled list of diseases and do not even make provision for periodic revision of the list. Texas is one of the last to pass such a scheduled law, and it will be interesting to see what our own New England state of Vermont passes in the next session of the legislature when the matter is to come up.

continued on page 497

CONTINUOUS LUMBAR PERIDURAL ANESTHESIA IN OBSTETRICS*

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SINCE THE DISCOVERY of continuous caudal anesthesia in 1942 by Hingson, Edwards, and Southworth, a rapidly increasing number of obstetricians and anesthetists have become interested in its application for obstetrical anesthesia. An extensive report this year by Hingson, Edwards, Lull, Whitacre, and Franklin,[1] reveals that 264 papers have been published in medical literature recording results in more than 600,000 cases. In this same report, figures are presented which indicate a reduction in stillbirths and in neonatal mortality when patients are delivered with continuous caudal anesthesia. Other workers[2, 3, 4] employing spinal or caudal methods of anesthesia have also been impressed with the well being of the baby at delivery. This feature alone, the possibility of saving infants, will serve as a stimulus for a more extensive use of continuous caudal anesthesia throughout the country. Furthermore, it offers a dramatic and complete relief of obstetrical pain in contrast to the varying results frequently seen with the more common schemes of obstetrical anesthesia.

On the other side of the ledger are certain hazards and disturbances of labor that are associated with continuous caudal anesthesia. Serious circulatory embarrassment may result from accidental injection into the subarachnoid space, too high a level of anesthesia, and in the occasional patient with a very labile blood pressure. The situation can usually be corrected by a prompt institution of supportive measures but fatalities are on record. Another very disturbing complication is infection of the sacral canal. Ellis and Sheffrey,[5] in an article dealing with mortality under continuous caudal anesthesia, give a brief account of one such case which caused the death of the patient. In addition, one must consider the advisability of frequent forcepts delivery and an occasional case of arrested labor. The present status of continuous caudal anesthesia is certainly open to argument, and strong support can be found for both sides of the issue.

Recently, one of us had the pleasure of hearing Dr. Manuel Curbelo[6] of Havana, Cuba, describe a technique for the continuous administration of lumbar peridural anesthesia by means of a ureteral catheter. He discussed the procedure in relation to abdominal surgery, and a report of his work is due to appear in one of the anesthesia journals this year. Dr. Curbelo's method appeared very tempting as a more suitable form of obstetrical anesthesia for two reasons: first, the needle puncture is made in the relatively clean lumbar region rather than at the highly contaminated sacral area; and, secondly, it seemed probable that satisfactory anesthesia could be established with smaller amounts of the same anesthetic solution.

A few sentences will explain the relationship between lumbar peridural anesthesia and caudal anesthesia. In the caudal technique, a needle is passed through the sacral hiatus at the lower end of the spine and advanced into the sacral canal. An anesthetic solution injected in sufficient volume not only fills the sacral canal but also extends up into the lumbar and finally the thoracic region of the spinal column. This solution is outside of the dura and may be described as peridural in its distribution. It has been demonstrated by Dogliotti[7] and others that a space or area of very loose tissue surrounds the dura and even extends along the spinal nerves beyond the confines of the spinal column. In the case of lumbar peridural anesthesia, the difference in technique is simply one of approach to the peridural space. The needle is inserted between the spinous processes of two lumbar vertebrae and advanced until its tip lies within the peridural tissue or space. To institute a continuous technique it is necessary to use a 16 gauge Huber point needle for the puncture, pass a ureteral catheter into the peridural space by way of the needle, and then withdraw the needle back over the catheter. As early as 1930, Dogliotti practiced "one shot" lumbar and thoracic peridural anesthesia extensively. His excellent text on anesthesia published in 1939 describes the procedure in detail and discusses its advantages and disadvantages.

continued on next page

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Details of Technique

With the patient in either the lateral recumbent or sitting position, the skin is prepared in the usual manner for lumbar puncture. A number 3½ ureteral catheter is examined for any possible defects and rinsed with sterile saline. The anesthetic solution may be conveniently prepared by dissolving 1 gram of procaine in 66 cc of sterile normal saline to make a 1½% solution. We have also used 1½% metycaine with good results. This solution may be used for the skin wheal which is made in the 4th lumbar interspace. The skin is then punctured with a Sise introducer to prepare the way for the more blunt Huber point needle. A 16 gauge Huber point needle is examined to note the lettering on that side of its hub which faces in the same direction as the lateral opening at the tip of the needle. The Huber needle is then inserted in the usual manner of lumbar puncture for a depth of approximately one inch. Considerable care is exercised to keep the needle in the midline of the patient's back. At this time, the stylet is removed and a 5 cc syringe containing normal saline is attached to the hub of the needle. The needle is now advanced a few millimeters at a time and the resistance offered to moderate thumb pressure on the plunger of the syringe is checked frequently. When the tip of the needle reaches the ligamentum flavum, an increased resistance to further advancement will usually be noted. At this time, it is wise to use the thumb and index finger of both hands on the shaft of the needle, while the ulnar surface of one hand is held firmly in contact with the patient's back to prevent the needle from plunging too deeply as it suddenly breaks through the ligamentum flavum. Once the needle point has pierced the ligamentum flavum, it will be found that very gentle thumb pressure on the plunger will cause the syringe to empty its solution into the peridural space. In some individuals, the piercing of the ligamentum flavum is not readily appreciated and the absence of resistance to injection will be the only evidence of successful peridural puncture. A few of our patients have shown only mild resistance to injection when the needle point was obviously in the soft tissues of the back; but a complete absence of resistance will not be found before entering the peridural space if the needle is kept in the midline. When it appears that the peridural space has been entered, the syringe is removed and the lettering on the hub of the needle is again noted to make certain the lateral opening of the needle tip is still facing cephalad. The approximate number of centimeters of needle that remain protruding from the patient's back is estimated. This figure subtracted from 9 centimeters (the over-all length of the Huber needle) gives the depth from the patient's skin to her peridural space. The No. 3½ ureteral catheter is now passed through the needle until approximately 6 cm. of catheter have entered the peridural space. This 6 cm. plus the 9 cm. within the needle will give a reading of 15 cm. on the catheter at the hub of the needle. Gentle but steady forward pressure is now made upon the catheter as the Huber needle is withdrawn from the patient. The catheter is never drawn back through the needle for any reason because such a maneuver may shear off a portion of the catheter within the patient's peridural space or lumbar tissues. With the needle removed the centimeter marking of the catheter where it just enters the skin is noted to be sure that the catheter has not been unduly advanced by the forward pressure exerted upon it. The reading taken at this time will equal the distance from the skin to peridural space plus the centimeters of catheter that lie within the peridural space. In the average individual, a reading of approximately 12 cm. shows proper placement of the catheter. Correction is made if necessary by withdrawing the catheter to the proper marking. Adrenalin is added to the previously prepared solution of 1½% procaine or metycaine to make a final dilution of 1:200,000 adrenalin. If using 66 cc of anesthetic solution, 0.33 cc or 5 minims of 1:1000 adrenalin will give a satisfactory dilution. The addition of adrenalin is purposely delayed until this time so that the anesthetic solution may be used without the vasoconstrictor in case of accidental puncture of the dura and arachnoid. A No. 24 needle is inserted into the ureteral catheter and a 20 or 30 cc syringe containing the anesthetic solution is attached to the needle. A test dose of 4 cc is injected as a check against the possibility of subarachnoid anesthesia, and the patient is assisted to the dorsal recumbent position. On a few occasions, we have found it difficult to make the injection even though considerable pressure was exerted upon the plunger of the syringe. The situation has been overcome in each instance by withdrawing the catheter 1 or 2 cm. If signs of subarachnoid anesthesia have not appeared after 6 minutes, the first anesthetic dose of 8 cc is injected. Evidence of peridural anesthesia should appear approximately 10 minutes later, but as much as 20 minutes may be required for the maximum effect of any injection. In patients with long spines, 10 or 12 cc may be needed to establish the desired anesthesia with the first anesthetic dose. We have seen patients with anesthesia through the 11th dorsal segment, but with only partial or incomplete anesthesia of the perineal region. If such is the case, the next injection is increased by 2 cc and the patient is put in about 10 degrees reverse Trendelenberg position to favor a caudal spread of the solution. This will establish complete perineal anesthesia without unnecessary upward spread of the anesthetic level. All of our

anesthesias have been administered with the patient on the delivery table, and we question the advisability of moving these people about with a ureteral catheter in place. They remain on the delivery table until the catheter is withdrawn. It has not been necessary to administer vasoconstrictors other than the adrenalin contained in the anesthetic solution in this series of cases. Minor falls in blood pressure have occurred, however, and equipment for combating any serious disturbance is always at hand. It has been found that an anesthetic dose will last about 45 minutes to 1¼ hours with the procaine solution and slightly longer when metycaine is used. Subsequent injections are given as needed for the patient's comfort or when the level of anesthesia begins to fall below the 11th dorsal segment. The management of labor under lumbar peridural anesthesia is the same as with continuous caudal anesthesia, and the subject has been adequately covered in numerous reports.

Discussion Continued

In considering the possible advantages of the lumbar approach, we would like to state that the possibility of complicating infection with lumbar peridural anesthesia seems very remote if reasonable precautions are exercised. We feel justified in making this statement not from our own brief experience but for the following reason. During the past two or three years, anesthetists throughout the country have accepted and applied extensively an almost identical technique to establish continuous spinal anesthesia. To our knowledge, no cases of complicating infection have occurred. It is granted that the presence of a ureteral catheter in the patient's lumber tissues must be considered as an avenue of infection if allowed to remain for a long period of time. We have established a policy of limiting the procedure to a maximum of 6 hours to prevent such an occurrence. We also believe it is much simpler and more practical to employ other methods of pain relief for the major portion of a long labor. Peridural anesthesia is not started until it appears likely that the patient's cervix will be fully dilated in less than 4 or 5 hours.

The second consideration of lumbar peridural anesthesia; namely, the possibility of reduced dosage of anesthetic drug, proved to be very gratifying from the start. It was found that only one-third of the recommended caudal dose was required to establish the initial level of anesthesia. When fractional or maintenance injections are needed to prolong the anesthesia, the lumbar technique requires approximately one-half the caudal dosage. We do not believe anyone will question the wisdom of establishing an identical state of anesthesia with a smaller quantity of anesthetic drug. Those of us who employ these local anesthetics frequently are acutely aware of the disturbances they may cause when absorbed in large quantity by the general circulation. The saving or reduced dosage by the lumbar technique should lower the incidence of such reactions. Also, it seems likely that by working with smaller volumes of solution a more delicate control of anesthetic distribution will be possible. This feature should help to avoid undesirable high levels of anesthesia and their penalty of circulatory and respiratory embarrassment.

In the practice of local, regional, and peridural anesthesia, it is customary to add adrenalin to the anesthetic solution. It serves the dual purpose of delaying absorption and prolonging the anesthetic effect;—a final dilution of 1:200,000 is the customary concentration. It has been our experience that individuals show a marked difference in their reaction to this drug. Rapid pulse, muscle tremors, apprehension, and pounding headache are occasionally seen with as little as 4 or 5 minims of the 1:1000 solution. In the lumbar technique, the combined test dose and first anesthetic dose contain only 1 minim of 1:1000 adrenalin as compared to the 3 or 4 minims administered in the caudal technique.

The literature on continuous caudal anesthesia has described two technical difficulties that may prove less troublesome with lumbar peridural anesthesia. One of these is the occasional inability to maintain a satisfactory level of anesthesia. It seems reasonable to expect a smaller percentage of failures with the lumbar technique because the injections are made about midway between the upper and lower limits of the nerves we hope to anesthetize. With the caudal approach, some of the anesthetic solution must travel twice as far which requires the establishment of a head of pressure in the sacral canal. A second technical difficulty has been described by Hingson (1) as arrest of labor from "prolonged dependent migration of the anesthetic solution through the sievelike openings of the anterior sacral foramina involving Frankenhäuser's ganglions". Here again it seems probable that because of the smaller volumes employed in the lumbar approach a reduction in the incidence of arrested labor may be achieved. We hasten to add that thus far we have used lumbar peridural anesthesia successfully on only 26 patients and are not qualified to pass judgment on these considerations.

The practicability of peridural puncture will be a disturbing thought to many anesthetists who pause to consider this form of anesthesia. One of us with extensive experience in "spinal" puncture, but with no previous experience in peridural puncture has been able to introduce the catheter into the peridural space in 26 of his first 29 attempts, or 89%. The punctures were made with the patient

continued on page 493

MINUTE ADOPTED BY THE BOARD OF TRUSTEES OF BUTLER HOSPITAL, PROVIDENCE, ON THE RETIREMENT OF ARTHUR H. RUGGLES, M.D., AS PHYSICIAN-IN-CHIEF AND SUPERINTENDENT

THE BOARD OF TRUSTEES has accepted the resignation of Dr. Arthur H. Ruggles as Physician-in-Chief and Superintendent with profound regret but with a sense of its obligation to recognize his right to be relieved from the burdens of the office which on January 1, 1948, he will have filled for twenty-six years — burdens which at all times have been heavy and during the period of the war were extraordinarily heavy.

The Board deems it fortunate that the Hospital is to have the benefit of his counsel in the new office of General Consultant.

The relationship between Dr. Ruggles and the Trustees has been far more than a merely official relationship. It has been one of personal friendship. They hope that it has brought to him a realization of the respect, admiration and affection with which they regard him.

Dr. Ruggles was appointed Assistant Superintendent of Butler Hospital in 1909 upon the completion of his interneship at the Rhode Island Hospital. On January 1, 1922, he succeeded Dr. G. Alder Blumer as Physician-in-Chief and Superintendent, and he has served in this office longer than any of his five predecessors.

During his incumbency of this office the Henry C. Hall Dormitory for nurses has been erected; the Hobby Shop has been enlarged and reequipped; and an addition to Ray Hall providing better facilities for church services, occupational therapy and recreation has been constructed. In addition, the other buildings at the Hospital have in many respects been improved, and special attention has been given to the interior decoration of the wards, with a view to rendering the patients' environment pleasanter and more cheerful.

But Dr. Ruggles' chief achievement at the Hospital has been not the enlargement or improvement of its plant but the increasingly successful treatment of its patients. In 1922 the Hospital had approximately the same number of beds as in 1945; but in the earlier year 151 patients and in the latter year 200 patients were admitted. This increase in the number of patients admitted roughly approximated the increase in the number of patients whose improvement was such as to permit their discharge. This success in the treatment of patients has been made possible by the utilization of improved methods of treatment, and these have required an enlargement of the Hospital's staff. In 1922 the Hospital had five resident physicians; today it has nine. In 1922 it had neither a psychologist nor a social worker. Today it has two psychologists, an interne in psychology and a social worker.

In Dr. Ruggles' view the function of a hospital like Butler Hospital is not limited to the treatment of patients who need hospitalization. He has believed that such a hospital should also take measures to treat the mentally ill in time to avoid the necessity of their hospitalization. To this end in 1945 Butler Hospital established an out-patient clinic. This has rendered valuable service to veterans and others whose cases, if not treated in time, would have required their admission to a hospital.

During his incumbency of the office of Physician-in-Chief and Superintendent Dr. Ruggles has brought about changes in the Hospital's School of Nursing to meet the new conditions affecting the education of nurses. In 1922 the Hospital conducted a small three-year training school; but as time passed, a trend developed toward confining the general training of nurses to schools conducted by the general hospitals. Therefore, in 1939, in recognition of this trend, Butler Hospital discontinued its general training school and established a three-months' course in psychiatric nursing for students in the general training schools. At present in each year about 300 students from fifteen training schools attend this course.

In addition, Dr. Ruggles has had a high sense of the obligation of a physician in his position and of his outstanding ability to participate in the movements directed toward the prevention of mental disease and the improvement of its treatment. He has been one of the leaders in the mental hygiene movement, and was for eight years President of the National Committee for Mental Hygiene. He was one of the organizers of the Rhode Island Society for Mental Hygiene and later its President. For four years he was Secretary, and in 1942 he was President, of the American Psychiatric Association. He has written and lectured widely on the subject of mental health, and in 1932 delivered the Colver lectures at Brown University, the title of his lectures being "Mental Health, Past, Present and Future."

In World War I he served as a major in the Medical Reserve Corps, organized the first neuro-psychiatric unit for service in France, and was successively Psychiatrist to the Second Division, Consultant in Neuro-Psychiatry to the Chief Surgeon of the United States Army in Great Britain and Medical Director of Base Hospital 214, A. E. F. In World War II he was a Consultant to the Secretary of War and the Chairman of the Committee on War Psychiatry.

Any account of Dr. Ruggles' work would be incomplete if it failed to mention the help which he has given to hundreds of persons, having no claim on him except that of their common humanity, who have come to him for counsel in their perplexities and troubles. The value of his help has been immeasurable and his generosity limitless.

Through the years during which Dr. Ruggles has been at Butler Hospital his skill and understanding have lightened the burdens of thousands of patients and their families. His reward must be found in his knowledge of this and in their thankfulness. The debt of the Hospital for all that he has done for its welfare and advancement is of a kind which cannot be repaid. The Board of Trustees can only express to him its gratitude and its hope that, relieved from the burden of administering the Hospital, he may have before him many years of happiness and of service to the causes to which he has devoted his life.

CONTINUOUS LUMBAR PERIDURAL ANESTHESIA IN OBSTETRICS

concluded from page 491

in the lateral recumbent position except for one instance where the sitting position was used for an obviously difficult spine. It is expected that with more experience the percentage of successful punctures will be in the nineties. A more frequent use of the sitting position will be used, if necessary, to obtain a highly practical number of successful peridural punctures. The authors prefer the lateral recumbent position for the patient's comfort. Unquestionably, the inexperienced anesthetist will have frequent failures until he develops the "knack" of peridural puncture. It should be recalled that inability to enter the sacral canal is by no means a rare occurrence in the practice of continuous caudal anesthesia.

Summary and Conclusions

The authors are of the opinion that continuous caudal anesthesia will be used more extensively in the future because of recent reports which indicate a reduced fetal mortality in patients delivered with this form of anesthesia. In addition to the possibility of saving infants, it offers a dramatic and complete relief of pain during the most trying portion of labor. Some of the hazards and complications of caudal anesthesia have been mentioned briefly.

A closely related anesthesia procedure; namely, the ureteral catheter technique of continuous lumbar peridural anesthesia has been described in detail and its apparent advantages considered. Our experience has been limited to 26 cases. In an additional 3 patients, we were unable to establish lumbar peridural anesthesia because of inability to locate the peridural space. It is felt that the percentage of successful anesthesias will increase with more experience. We believe the catheter technique of continuous lumbar peridural anesthesia is worthy of a more extensive trial and we recommend it for consideration to anesthetists engaged in obstetrical anesthesia.

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OBSERVATION AND DIAGNOSIS

There was an old man who said: "Hush,
I perceive a young bird in that bush."
When they said "is it small?"
He replied "not at all,
It is three times the size of the bush."

EDWARD LEAR

WILLIAM HUMBOLDT, the elder brother of the more famous Frederick the naturalist, once remarked that "to behold is not necessarily to observe, and the power of comparing and combining is only to be obtained by education." Edward Lear, who like many humorists had a strong tincture of common sense in his make-up, suggested the same idea in the verse quoted above, for to perceive is something more than to see, and in medicine one of the chief objects of training should be to sharpen the powers of perception, which while they normally vary considerably in acuity in different people, can definitely be improved by practice.

Diagnosis, as an experienced physician can testify, is at times a very simple matter and at other times a very complicated performance; but in either case one of the most important factors in reaching a conclusion is the power to observe accurately. It might be surmised that in these days of specific or near-specific technical diagnostic procedures the cultivation of the powers of observation, which include not only sight, but hearing, touch and even smell, has become less necessary than it formerly was, and there is little doubt that the mere existence and multiplicity of such tests has made many physicians careless about cultivating their observational powers, and indeed about some other essentials such as competent history taking. Why bother to observe acutely, to compare, to combine and to deduce, when the Xray, the Electrocardiograph, or some bacteriological, chemical, or serological tests may give you the answer without the painful effort of thinking?

The answer to this type of reasoning is that it is fallacious because acute powers of observation and deduction are often needed in the interpretation of technical results, because none of the common technical tests is one hundred percent efficient, because no one of the interpreters is always right, and because, for these reasons, the diagnosis of

disease, particularly in obscure and atypical instances, can be reached only by careful consideration of all the facts and not always even then.

The Wassermann test, for example, fails in a certain percentage of patients with active syphilis and is occasionally positive in diseases other than lues; the Widal reaction and all comparable agglutination tests are none of them one hundred percent sure fire, and may be hangovers from infections long past and are occasionally non-specific; the radiologist, who interprets shadows, cannot be expected to hit the bullseye every time; and the tracings procured by Electrocardiography are sometimes ambiguous and even misleading. It is doubtless true that in terms of percentage the errors in many of these tests are small, but while those dealing with infections are fairly specific there are others which merely point to damage to some special organ, liver function tests for example, but do not reveal the particular etiological factor. They are like the revelations of cerebral localization which indicate the site but not the nature of the lesion.

We must, I think, conclude that no matter how many specific technical methods are devised, there will always be occasion for the use of cultivated powers of observation and deduction in diagnosis. A dermatologist who fails to recognize syphilis because the Wassermann happens to be negative, or an Internist who misses a case of typhoid fever because the Widal reaction is absent, are not very brilliant exponents of medical science and art. We have only to read the records of our medical ancestors who flourished before the technical era to be convinced of the possibility of recognizing even obscure cases of disease by the use of good histories, thorough physical examinations and a vigorous use of the gray cortex. This is not to decry the value of modern methods, but to emphasize the importance of continuing to cultivate some of the older techniques which are in danger of being overshadowed at a time when their use is still of the greatest importance. *G. B.*

SEAL OF APPROVAL

The announcement by the Health Insurance Committee that the Rhode Island Plan, the voluntary prepaid surgical-obstetrical program of the Society, has been awarded the Seal of Acceptance of the Council on Medical Service of the American Medical Association adds further prestige to it. Approval by the Council on Medical Service is granted only after the program is carefully checked as regards its sound operation and careful medical supervision.

Within the past month participating physicians have been supplied with informative brochures and with a pad of direction to pay and physician agreement forms. Several insurance companies have announced that they are preparing promotional campaigns for the Fall, and with many sales already reported we look forward confidently to the development of the program in the coming months.

It is interesting to note that the Maine and Tennessee state medical associations have, by vote of their respective Houses of Delegates, decided to develop their surgical insurance plan along the line of ours. Others already in the field with us include Wisconsin and Illinois.

The progress of plans utilizing private insurance companies received support at the recent AMA meeting when the Council on Medical Service agreed to assist the various interested states in preparing informative data on this type of program. Representatives of nine states met in Chicago in June to outline procedures to be followed in extending prepaid insurance for medical care through policies endorsed by state medical societies and merchandised by the insurance industry.

MEDICAL TEACHERS

As we have pointed out previously, the fact the Rhode Island has no medical school does not in any manner whatever indicate that the medical personnel in this state ranks less equally with those of other states in all phases of service, including medical teaching. On several occasions we have noted the accomplishments of, and the honors to, Rhode Island physicians.

Again we report with pride the appointment of four Fellows of the Society who have been selected during this summer for teaching roles in foreign lands. On July 1, Dr. Meyer Saklad, director of the anesthesia department at Rhode Island hospital, was selected as a member of a medical mission which has conducted lectures for European physicians during the past six weeks in Warsaw, Piekary, at the University of Krakow, the University of Turku, and at Helsinki.

This month Dr. Alex M. Burgess, former chief of medical service at Rhode Island hospital, and Dr. Peter Pineo Chase, editor of this JOURNAL, and also president-elect of the Society, start a two month lecture course in Germany. Their task will be to bring up to date physicians who have been cut off from medical developments for years because of concentration camp or displaced person camp detention.

To Brazil has gone Dr. Eugene A. Field who was invited to deliver lectures on radiology at the medical school in Rio De Janeiro, and who will also give a scientific lecture in Portuguse to the entire medical profession of the city during his visit.

It is a source of gratification for all Rhode Island Physicians to note the recognition to these members of the Society. For Doctors Saklad, Burgess, Chase

continued on next page

and Field the acceptance of the teaching assignment, with all the work it entails, represents a notable personal contribution to the advancement of medicine and the health of the people in the countries they will visit.

THE FISKE FUND

The recent action of the court in authorizing the investment of the Fiske Fund of the Society in securities that will realize a greater return, thus providing income to permit the award of an annual cash award for the prize essays, is indeed good news. The ruling of legal counsel for the fund in 1941 that the spending of more than the usual income was to be considered a definite breach of trust resulted in the suspension of activities as regards the annual Fiske Essay. The annual income from the bank deposit would not suffice for the payment of the prize award and the incidental expenses necessary for the publicizing of the contest.

Hence the recent action which resulted after the Council of the Society had authorized the Fiske Fund Committee to seek court transfer of the funds to government security bonds, or other reputable investment that would provide a greater annual revenue. By this action it is hoped that within the next year the fund will be in a position to permit a $150 prize, and also provide the incidental expenses of the contest. The fund at present totals $12,954.21.

It was in 1835 that the Society received through the will of Dr. Caleb Fiske the original trust of $2,000 the income of which was to be used to pay a premium or premiums for the best treatise or treatises on the subject proposed by the Trustees of the fund. The first award was made to Dr. T. H. Webb in 1836 whose essay was on "Rheumatism, Its Causes and Treatment". Since that date 69 additional awards have been given, the most recent in 1941 to Dr. Adolph Eckstein of Providence for his essay on "The Surgical Treatment of Peptic Ulcer."

THE C. V. CHAPIN FELLOWSHIP

The creation by the late Mrs. Charles V. Chapin in her will of a Charles V. Chapin Fellowship for Research in Contagious Diseases adds another outstanding contribution to the memory of her famous husband whose lifetime in public health work won for him world-wide renown.

Through this bequest the governing board of the Chapin hospital is authorized to designate from time to time a person to carry on research work in the study of contagious diseases. The gift is made on the express condition that the hospital shall provide at its expense room, board and suitable equipment at the hospital for the person designated for the fellowship award.

The recipient of the fellowship, upon accepting the appointment, is expected to devote his entire time, free from routine work at the hospital, to research work.

Should the governing board of the hospital find that it is unable to comply with the conditions of the will, or if in any consecutive period of two years no person is carrying on the research work, the entire trust terminates and is transferred to the Rhode Island Foundation which may in its discretion continue the Chapin Fellowship, or otherwise dispose of the funds for charitable purposes.

We are certain that the governing board of the hospital will never have to relinquish the trust, and we hopefully look forward to some worthwhile research in the study of contagious diseases by Chapin Fellows in the years ahead.

PHYSICIANS NEEDED FOR DRAFTEE EXAMINATIONS

Members of the Society interested and willing to assist the U. S. Army and U. S. Air Force Recruiting Service in the physical examination of draftees are requested to communicate with Captain Kirke B. Everson, Jr, recruiting officer, at the Recruiting Main Station at 37 Exchange Place, Providence.

The preliminary induction examination consists of both a mental and physical examination. All examinations will be paid for on a fee basis, as follows: $5 for the first man to be examined; two dollars for each additional man examined, with a maximum of $25 paid for any one day's work.

The Recruiting Office anticipates a daily flow of 35 to 50 persons for physical examinations by late September or early October. Hence two physicians as a minimum will be needed for each day for about three hours (between 10 a.m. and 2 p.m.). Specialists will also be needed by the Service to determine doubtful cases.

LIBRARY HOURS

During the month of August the Medical Library will close at 1 p.m. daily, except Saturday when the closing hour will be 12 m.

INDUSTRIAL HEALTH

concluded from page 488

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THE GENERAL PRACTITIONER IN NEW ENGLAND HOSPITALS

(A report with comments to the Council of the New England State Medical Societies, presented by the Executive Secretary at the Annual Meeting, at Boston, Massachusetts, April 21, 1948.

THE ROLE of the general practitioner in American medicine has received increasing attention in the past few years. Two factors have contributed to bring about this revival of interest — (1) The tremendous trend towards specialization which has resulted in a more notable division within the profession, and (2) the adoption by hospitals of staff rules and regulations restricting practice in hospitals.

As pointed out by Johnson[1] there were about 5,100 residents in hospital residencies at any one time before the war, whereas today there are some 12,000. It is not within the province of this limited report to discuss at any length the reasons prompting such a sizeable increase in the number of medical graduates who are continuing training to become specialists. That the field of modern medicine has become increasingly complex, thereby necessitating the development of specialties with which the public is becoming more and more familiar, is well-known.

But physicians trained for specialty work naturally locate in urban areas, and the question may well be asked whether our communities will be in a position to absorb the specialists in the proportion now being trained. The various American Boards are reported to be concerned by the large numbers seeking certification. Therefore a study might well be initiated of the factors contributing to the trend towards specialization. Undoubtedly such a study would include in its findings the tendency of some hospitals to limit their staff appointments to those physicians with Board certification.

Recognition that the general practitioner is being restricted more and more as regards hospital practice has been noted in many publications. The Journal of the American Medical Association editorially[2] cited the position of organized medicine on the matter last August, stating that

"Any rule barring a physician from staff privileges because he does not possess a certificate from one of the specialty boards or membership in a special society is not in accord with the expressed policy of the American Medical Association and the Advisory Board for Medical Specialties. Hospital staff appointments should depend on the qualifications of physicians to render proper care to patients as judged by the professional staff of the hospital and not on certification or special society membership."

Of paramount importance is proper medical care to patients. Unquestionably the average person wants capable and experienced physicians for what is termed specialty work, in or out of the hospital. But at the same time he considers the general practitioner, or as he is more familiarly called, the family doctor, trained to render care for the great majority of illnesses regardless of their severity. The situation is most perplexing when the general practitioner, for example, treating a child for pneumonia and wishing to give penicillin in the hospital has to relinquish the patient to a specialist because of hospital restrictions.

This example can be multiplied manyfold, and it becomes increasingly embarrassing to the physician in general practice, and most confusing to the patient whom we teach to seek advice from the doctor of medicine. With the tremendous growth of hospitalization and surgical-medical insurance plans the probem is augmented by the increasing demand for medical care in the hospital. The question may well be asked — should the general practitioner not have part in the care of his patient whom he refers to the specialist, so that the medical care given in the hospital will be his intimate knowledge when the patient is returned to him?

In an effort to find out what the privileges and restrictions are relative to practice in the hospitals in New England by general practitioners, an inquiry was directed to approximately fifty hospitals in the region. Replies were received from twenty-

continued on page 500

[1] The General Practitioner and His Opportunities, Victor Johnson, M.D., J. Omaha Mid-West Clinical Society, Jan. 1948.

[2] The hospital and the general practitioner (ed.), J.A.M.A. 134:1484 (Aug. 23) 1947.

Report of the Committee on Therapy of

THE AMERICAN ACADEMY OF ALLERGY

on HYDRYLLIN

The results of the study:

		60% to 100% EFFECTIVE (Regarded as "Good")	40% to 60% EFFECTIVE (Regarded as "Fair")	0% to 40% EFFECTIVE (Regarded as "Poor")
Hay Fever	790 CASES	304 (38%)	234 (30%)	252 (32%)
Asthma	397 CASES	119 (30%)	82 (21%)	196 (49%)
Pollen Asthma	226 CASES	73 (32%)	55 (24%)	98 (44%)
Vasomotor Rhinitis	130 CASES	20 (16%)	42 (32%)	68 (52%)
Urticaria	24 CASES	4 (17%)	8 (33%)	12 (50%)
Eczema	3 CASES			3
TOTAL	1,570 CASES			

Side Reactions

No Reactions . . . . . 1,219 Cases (72%)
Moderate Reactions . 314 Cases (20%)
Severe Reactions . . . 126 Cases (8%)

Conclusion From these figures is would seem that the preparation has a fair degree of effectiveness in hay fever. In the asthmatic cases, both those with asthma due to pollen and those having asthma from other sources, the figures of the effectiveness of the drug are more impressive than those of other antihistaminics.

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THE GENERAL PRACTITIONER IN NEW ENGLAND HOSPITALS

continued from page 498

seven, including at least one answer from each of the New England states. Some of the large hospitals evaded the question. Nearly all indicated that the tendency is towards concentration in specialties for staff privileges, with the specific criterion qualification by one of the various Boards or Colleges. Very few give the general practitioner much opportunity to render care for the majority of his patients. The most favorable report in this respect, from a 480 bed general hospital, stated:

"General practitioners may be appointed to any position in our hospital by the Board of Trustees on the recommendation of the Staff Advisory Committee which considers their general and specialized qualifications. There is no staff rule or regulation which prohibits the general practitioner from participating in any activity on the service to which he is assigned if he is considered qualified by the chief of the service.

"In practice, the general practitioner or the so-called 'Specialist' who does not limit his practice may be promoted to a position on our staff in any medical or surgical specialty provided he has demonstrated that he is qualified for the position. Accordingly, there are instances in our staff where men, who must be technically called general practitioners, have achieved the rank of seniors in specialty services.

"Usually the man with a house service in our hospital limits his practice in the hospital to that service although he may practice general medicine outside of the hospital. There are very few instances where men who are not classified as obstetricians deliver babies in the hospital and yet are members of other specialty services. In practice there are becoming fewer as time goes on."

Many hospitals either have or contemplate a "credentials committee" to decide on the privileges of the physicians to be on the active staff, in accordance with College and Board recommendations. The privileges are for the most part in three categories, permitting (1) full privileges, restricted to special field (i.e. Medicine, Surgery, etc.) (2) Intermediate privileges, the performance of certain procedures without supervision, and certain others with supervision; and (3) Minor privileges, allowing very few services without supervision.

The ramifications of this problem are many. The issue is one that can work to the disadvantage of organized medicine at a time when strength and unity of membership is of paramount importance. The public seeking medical service has every reason to be concerned with the regulations for the staffing of hospitals wherein an increasing amount of that service may be given in the future.

The suggestion appears worthy of consideration that the Council of the New England State Medical Societies establish a committee of its own, or for it, to make a complete study of this situation in the New England area in order to rationalize in this region what might be done in the best interests of the public and the profession to give the general practitioner hospital privileges.

APPENDIX

The Role of the General Practitioner in New England Hospitals

Note: The following abstracts are from replies to an inquiry as to privileges and restrictions for general practitioners in hospitals in the New Engand states. Names of hospitals are withheld.

Hospital "A" (General, 250 beds) (Population of Community over 250,000)

"In reply to your recent letter, we would say that we have a closed staff at this hospital and only members with regular appointments to the visiting staff are permitted to treat patients in the hospital."

* * * *

Hospital "B" (General, 281 beds) (Population of Community under 200,000)

"In answer to your letter of March 9, at the moment we have a number of men on our courtesy staff who are allowed the privileges of the hospital for their private and semi-private surgical patients. A small number of these are general practitioners.

"At the moment any medical man, a graduate of an approved medical school, may be granted the privileges of the hospital for his private and semi-private medical patients.

"It is now under discussion whether or not we are going to close the hospital to our appointed staff. Now our courtesy staff is provided the conveniences of the hospital but does not contribute to its educational program or charity work, and we think this is erroneous. I strongly suspect that this change will take place in the very near future."

* * * *

Hospital "C" (General, 172 beds) (Population of Communtiy under 100,000)

"Relative to your letter of March 9th, I think perhaps it will be more pertinent to give you the policy of this hospital as of January 1, 1949, since at that time we are dropping our present policies. In effect, there has been established a credentials

continued on page 502



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THE GENERAL PRACTITIONER IN NEW ENGLAND HOSPITALS

continued from page 500

committee. This credentials committee consists of the chief of each service. The function of this committee is to decide on the privileges of the men on the active staff. At the present time each man on service has been notified that beginning January 1, 1949, his privileges will be limited to the service to which he is now assigned. He may have major privileges with or without supervision and minor privileges with or without supervision. Additional privileges on other services may or may not be granted but may be applied for and would depend upon the qualifications of the man in the judgment of the Credentials Committee."

Hospital "D" (General, 294 beds) (Population of Community under 125,000)

"Referring to your communication of March 9, I wish to advise you that we have on our Courtesy Staff several general practitioners who have, through their experience, become qualified in major surgery and obstetrics as well as medicine and such Staff members are allowed to practice their profession here at————Hospital.

"There have been special instances where the character of the work performed has been felt by the Staff not up to standard and in such cases the Staff member has been restricted in his work or allowed to continue work under supervision.

"In the case of new men applying for Staff privileges, they have to specify as to what branch of medicine they are particularly interested in and after a review by the Credentials Committee and recommendations received, the Staff act on the applications, in most cases granting the privileges, and in others, granting less than what the applicant requested."

* * * *

Hospital "E" (General, 115 beds) (Population of Community under 50,000)

"Ordinary courtesy privileges given to the General Practitioner, allows him to take care of his medical cases, minor traumatic surgical cases, and obstetrical cases. If he is a duly qualified specialist in any branch, he is in turn, given privileges, Surgical and otherwise, as prescribed for his respective specialty."

* * * * *

Hospital "F" (General, 769 beds) (Population of Community under 200,000)

"The policy of the————Hospital is that general practitioners may be admitted on the courtesy staff of the hospital. We do not have any special section for general practice, nor do we allow the general practitioners to engage in any of the specialized procedures of medicine. At the present time the general practitioner is allowed to bring medical and pediatric patients to the Hospital and care for them as his own private patients. All general practitioners are under the Chief of Medicine or of Pediatrics, and their work is subject to the review and control of the Chiefs of the respective services.

"In a few selected circumstances, general practitioners are allowed to do normal obstetrics. These individuals apply for these privileges and are passed upon and recommended by the Chief of Obstetrics and Gynecology. If such courtesy privileges are given, the general practitioner does his normal obstetrics under the direction and control of the Chief of Obstetrics and Gynecology.

"Our general thinking at this time, and I believe that this attitude will continue, is that the general practitioner should continue to be afforded privileges in the hospital. It is by this method that the Hospital can assist in postgraduate education of doctors, and make available easily consultations whenever the practitioner feels that the problem warrants. It also provides a continuity between the home care of the patient and the hospital care, and yet if properly controlled, does not subject the patient to improper medical care."

* * * *

Hospital "G" (General, 182 Beds) (Population of Community under 125,000)

"The Staff of————Hospital is made up of Honorary, Retired, Consultant, Active, Out-Patient, and Courtesy members. All of these men have the privilege of referring patients into the Hospital, either as private or ward cases.

"In accordance with the desires of the American College of Surgeons and the Standardization Committee, special committees have been appointed to classify all members of the Staff for Surgical, Obstetrical, and T & A privileges. Classification of the members of the Staff has been reviewed with careful deliberation and carried out only with the interest of the public welfare in mind and the maintenance of high standards of medical care in the Hospital.

"The classification for Surgery is as follows:

Group I permits full privileges in the Operating Room.

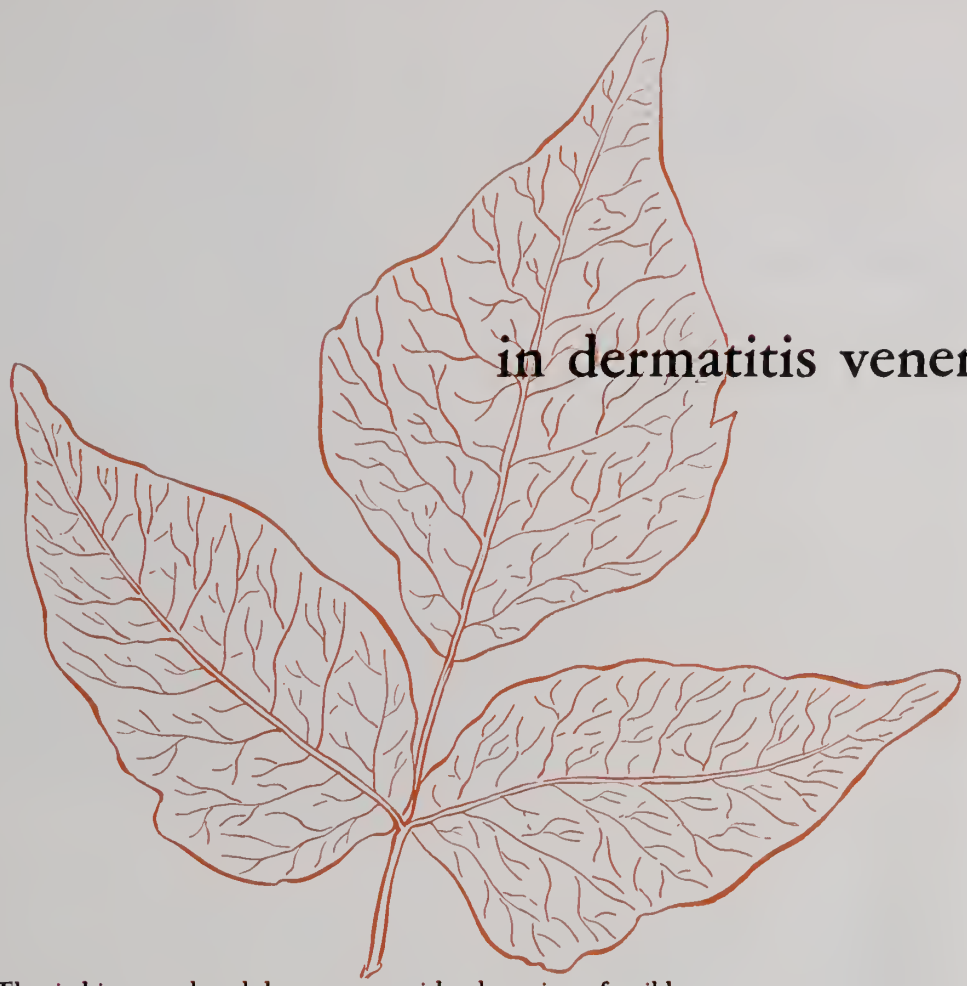
Group II required an assistant qualified from Group I.

Group III men have no operating privileges.

"The classification for Obstetrics:

Group I permits full and unrestricted privileges in Obstetrics, except Caesarean Sections,

continued on page 504



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THE GENERAL PRACTITIONER IN NEW ENGLAND HOSPITALS

continued from page 502

which are certified by the Surgical Committee.

Group II permits the use of low forceps; other forms of manipulative deliveries must be done in the presence of an assistant qualified in Group I.

Group III permits routine normal deliveries. No forceps or manipulations of any kind are permitted.

"Any Courtesy Staff man attending a medical case in the Hospital is required to obtain a Consultant in any serious case, unless he is a Group I man from one of the other hospitals. However, consultations are earnestly requested in all serious cases and in all cases where a Caesarean section is indicated."

* * * *

Hospital "H" (General, 227 Beds) (Population of Community over 250,000)

"The facilities of the Hospital have for many years been used to capacity by men specializing in surgery and internal medicine.

"At present there are no general practitioners on the staff."

* * * *

Hospital "I" (General, 164 Beds) (Population of Community under 50,000)

"The active medical staff shall consist of those physicians who have been selected to attend free patients in the hospital and to whom all such patients shall be assigned. Only members of the active medical staff shall be eligible to vote or hold office.

"No physician who is not resident in the community shall be eligible for membership on the active medical staff. Appointments shall be made by the governing board, after recommendation of the active medical staff."

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Hospital "J" (General, 449 Beds) (Population of Community over 250,000)

"We have at this hospital no policy for or against staff privileges for general practitioners, as our staff is a closed staff. I should say that some of the members of our Medical Service can be regarded as general practitioners although not quite in the same sense that general practice is conducted in our smaller cities and towns."

Hospital "K" (General, 226 Beds) (Population of Community under 50,000)

"At the present time, our established policy is to extend those privileges to a man which he is capable of fulfilling, regardless of formal educational or Board qualifications. It is true that most of the senior men on the specialized services are Board members and do restrict their practice as to the specialty which they represent.

"At the present time, we are at work on a system of staff evaluation."

Hospital "L" (General, 170 Beds) (Population of Community under 150,000)

"The medical staff of the————Hospital is a closed staff restricted to specialties in their respective divisions, with only one or two exceptions are either Diplomates of their respective Boards or eligible for certification. At the present time there are seventeen members on our staff. There are two on our honorary staff for they have retired from practice.

"At the present time general practitioners are not permitted staff privileges. Their patients must be referred to a member of our active medical staff."

* * * *

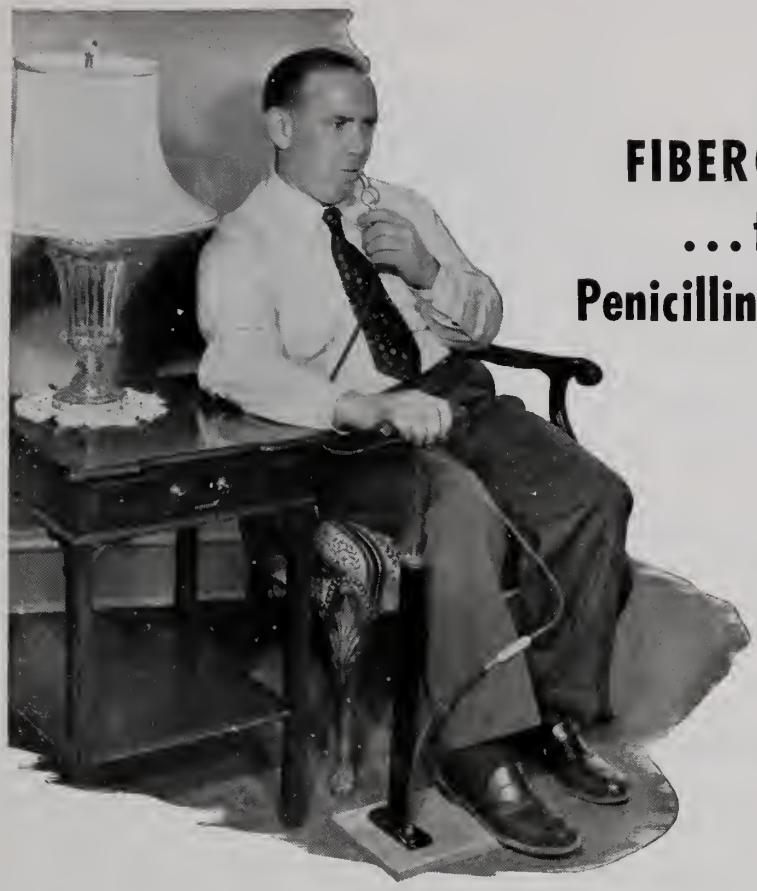
Hospital "M" (General, 215 Beds) (Population of Community over 250,000)

"The physician, when he applies, makes application for that particular specialty classification of the staff organization in which he is interested and in which he is competent — based upon his education and training. We do not have a staff classification for General Practitioners as such, although many of the physicians who are in the Internal Medicine division of the staff organization do general practice.

"Upon receipt of application, the physician's background and qualifications are very religiously reviewed by the Committee on Credentials, and their recommendation is sent to the governing board of the hospital through the Medical Executive Committee."

* * * *

continued on page 506



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†Finke, Walter, M.D., Simplification of penicillin aerosol therapy for home treatment, American Practitioner 1: 643-644, Aug. 1947.

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continued from page 504

Hospital "N" (General, 555 Beds) (Population of Community over 250,000)

"There has been no action taken, and there are no defined policies relative to restrictions to General Practitioners.

"However, the relationship of the general practitioner to the general staff structure of———— Hospital is under constant study.

"All doctors on the staff of the————Hospital have the privilege of bringing private patients and their privileges in this connection are defined by the Credentials Committee, in accordance with the qualifications of the individual.

"It is true, of course, that general practitioners are not and have not for years been allowed to practice the surgical specialties."

Hospital "O" (General, 308 Beds) (Population of Community under 125,000)

"Major privileges in any service will permit the physician to treat patients, on that service, for any cause.

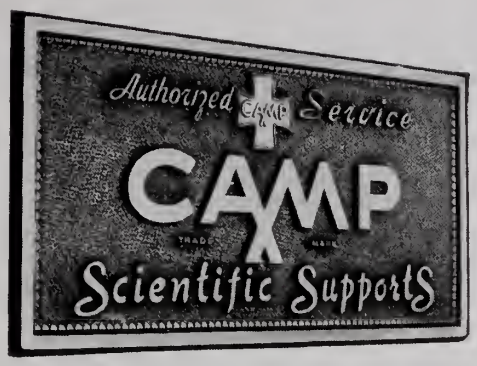
"A physician with intermediate privileges may perform in his service any procedure under the supervision and in the presence of any member of the Active, Associate or Consulting Staffs of said service with major privileges and after a consultation with such member at least twelve hours before operation, except in emergency, in which case consultation must be held before patient is under anesthesia.

"A physician with intermediate privileges on the Surgical service may perform the procedures listed under "A" without supervision; and under "B" under the supervision of a member of the Active or Consulting Staff of the service in which the procedure is to be performed.

"A. *Without Supervision*

1. Hemorrhoidectomy
2. Saphenous ligation
3. Closed reduction of simple fractures
4. Incision and drainage of infection not involving cavities
5. Fissure in ano
6. Fistula in ano
7. Amputation of digits
8. Suturing lacerations not involving tendons or nerves
9. Removal of simple cutaneous tumors
10. Ingrown toenails
11. Dilation and Curettage
12. Tonsillectomy and adenoidectomy
13. Hydrocele, uncomplicated
14. Skin grafts; Rividen and Thiersch only.

continued on page 508



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THE GENERAL PRACTITIONER IN NEW ENGLAND HOSPITALS

continued from page 506

"B. *With Supervision*
Any other minor or any major operation.

"A physician with minor privileges may perform in his service any of the procedures listed above under "A" under the supervision and in the presence of any member of the Active, Associate or Consulting Staff of said service.

"A physician with minor surgical privileges may perform any or all of the following procedures:

1. Cutting tongue tie
2. Removal of wens or simple lipomata, warts and uncomplicated moles
3. Incision and drainage of simple infections not involving tendon or facial planes or organs
4. Incision of furuncles
5. Paracentesis
6. Suturing of lacerations involving integument only
7. Incision peritonsillar abscess
8. Tonsillectomy in patients under 14 years of age
9. Adenoidectomy
10. Circumcision
11. Transfusion
12. Intravenous medication or venupuncture
13. Spinal puncture and other medical diagnostic and therapeutic operative procedures
14. Sclerosing of veins."

* * * *

Hospital "P" (General, 162 Beds) (Population of community over 250,000)

"All appointments to the Staff of the———— Hospital will be classified under Medicine, Surgery, Obstetrics and Anaesthesia. A member cannot hold both Medical and Surgical appointments, but must confine his work in the Hospital within the scope of either Medicine or Surgery. Appointments in Obstetrics and Anaesthesia, however, may be given to appointees in either Medicine or Surgery, if the applicant is properly qualified.

"Appointment to the Medical Staff gives to the physician the right to use the Hospital and its facilities for his private patients for the practice of the following:

General Medicine
Care of normal Obstetrical cases including those requiring minor plastic repairs
Simple Anaesthesia (Nitrous Oxide and Ether anaesthesia)
The privilege of assisting at major operations.

"Surgical Appointments with Major Privileges:

1. General Surgery. Major Surgical privileges may be given to Fellows of the American College of Surgeons or Diplomates of the American Board of Surgery.

2. Limited Major Privileges. Limited major privileges in General surgery may be given to the Junior members of the Active Staff, subject to the approval of the active Senior Surgical Staff.

3. Major Privileges in Special Branches of Surgery. Major privileges in special branches of surgery are given to Fellows of the American College of Surgeons or Diplomates of the American Board in their specialties. Surgeons having Major privileges in certain specialties only are limited to that specialty in this hospital.

"Surgical Appointments without Major Privileges:

Surgical appointments without major surgical privileges are given to those who have had special training in Surgery, but do not qualify for major privileges. Such appointments may permit the appointee to perform major surgery but only under the direct supervision of a member of the Surgical Staff who is a Fellow of the American College of Surgeons or Diplomate of the American Board of Surgery."

Obstetrical Appointments with Unlimited Privileges:

Such appointments are given to Fellows of the American College of Surgeons and to Diplomates of the American Board of Obstetrics and Gynecology, and the Chief of the obstetrical service of the Active Staff.

"Obstetrical Appointments with Limited Privileges:

Such appointments are given to those who have had adequate training in Obstetrics, but do

continued on page 510

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THE GENERAL PRACTITIONER IN NEW ENGLAND HOSPITALS

continued from page 508

not qualify for unlimited privileges. The appointees may perform all obstetrical procedures except Caesarian sections.

"Anaesthesiology:

Physicians on Medical Staff who are qualified in anaesthesia shall be given the privilege of practicing unlimited anaesthesia in the hospital, by the executive committee, after consultation with the Anaesthesia Staff."

* * * *

Hospital "Q" (General, 152 Beds) (Population of Community under 100,000)

"The Active Staff shall consist of all department or service Chiefs and those physicians who are annually assigned to attend all free patients who have not their personal Physicians, hereinafter called "Service Cases." Members of the Active Staff should preferably be F.A.C.S., or F.A.C.P., or a Diplomat of one of the Specialty Boards, or if there is no Board, a member in the National Organization which represents that specialty, or American Dental or National Dental Association. Members of the Active Staff only shall have active or passive vote in Staff Meetings."

* * * *

Hospital "R" (General, 527 Beds) (Population of Community under 200,000)

"It is our policy to send a letter to the doctors who are granted General Practitioner Privileges stating in full a detailed definition of what they are allowed to do."

Appointment to the courtesy staff with general minor privileges is set forth as follows:

"Minor Privileges have been defined as follows:

"Medicine: General Medical Cases may be cared for except that, for the protection of the Hospital, major problems in Medicine, such as Coma-Mental-Severe Cardiac conditions, or Pneumonia, shall have a consultation with a member of our Active Medical Staff.

"Surgery: Any operative procedure which can be done in a doctor's office, or in our Emergency Room, without anesthesia.

"Under Minor Surgery we have also included Circumcision, Incision and Drainage of superficial abscesses, and Suturing of Superficial wounds, which may be done with Anesthesia.

"Obstetrics: Minor Obstetrics includes only these procedures:

Spontaneous deliveries
Outlet (low) forceps with head visible
Frank breeches in multipara
Repair of first and second degree lacerations and episiotomies
Rupture of membrane after onset of labor

"It does not include the following procedures. These may be performed only by those having specialist privileges in obstetrics:

Cases complicated by constitutional diseases, such as heart diseases, diabetes, etc.
Caesarean Section
Bag Induction
Repair of third degree laceration
Version and extraction
Toxemias of pregnancy
Primigravidous Breeches
Multiparous footlings
Mid forceps
Scanzoni Maneuver
And all other obstetrical complications.

"Orthopedics: Fractures with no displacement nor joint involvement, as read by the X-Ray Department, and which requires no anesthetic.

"Major Surgical Privileges are granted only to those who have complied with, or are in the process of complying with, the American Board requirements in the Various Specialties. We shall be glad to extend further privileges upon request, and on evidence of Special training."

* * * *

Hospital "S" (General, 141 Beds) (Population of Community under 50,000)

"All practitioners are given courtesy privileges. Men on the staff are not given preference in hospital admissions. Every patient is admitted in rotation excepting, of course, emergencies. Places are always found for these.

"After April 1, 1948, the heads of the various services must be certified. Young men are admitted to the staff as associates and are given five years in which to obtain certification. If this is not accomplished they are continued as associates. The rule is not retroactive and any man now on the staff is retained."

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BIBLIOGRAPHY: 1. United States Dispensatory, ed. 24, Philadelphia, J. B. Lippincott Company, 1947, p. 1446. 2. Wiesbader, H., and Filler, W.: Am. J. Obst. & Gynec. **51**:75, 1946. 3. Allen, W. M.: South. M. J. **37**:270, 1944. 4. Lyon, R. A.: Am. J. Obst. & Gynec. **47**:532, 1944. 5. Groper, M. J., and Biskind, G. R.: J. Clin. Endocrinol. **2**:703, 1942. 6. Soule, S. D.: Am. J. Obst. & Gynec. **45**:315, 1943.

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RHODE ISLAND MEDICINE

Its Problems and Its Solutions

Prepared by the Committee on Public Policy and Relations of the Rhode Island Medical Society and published in the Providence Evening Bulletin, June 14-20, 1948.

I

THE EVENING BULLETIN recently completed a series of articles on American Medicine,—Diagnosis and Prescription. The author of the articles reportedly sought thoughtful answers from the nation's top physicians and public health experts to such questions as these:

Is there a shortage of physicians? Is socialized medicine the solution for our medical problems? Is there too much specialization? Why is it hard to get a doctor in an emergency? How can the cost of medical care be reduced? What are the major trends in American medicine?

The author of the articles reportedly visited key medical centers in this country, and talked with scores of leading physicians, medical educators, public health experts and others qualified to speak on the subject. The articles, according to the *Bulletin,* represented a "synthesis of the best thinking that is being done on the problem of how to bring adequate medical care to the people of the United States."

The Committee on Public Policy of the Rhode Island Medical Society has requested the opportunity to answer in this newspaper some of the conclusions incorporated in these articles.

The Committee is one entirely of physicians. It speaks with honesty, conscious of its obligations to the people of Rhode Island. It does not attempt to speak for the medical profession of the entire country, nor of the medical problems and their solutions throughout the nation, except in respect to phases where such problems affect Rhode Island directly.

The Medical Profession is not an organized group. It is a profession of individuals who are subject to all the human frailties of individuals. The Medical Society is merely an association of the individual physicians for the promotion of the science and art of medicine and the betterment of public health. The physicians of this state therefore claim for themselves no other prerogatives than those of any other citizens.

The Medical profession has read the articles in the *Evening Bulletin* that presented views and conclusions attributed to "the men who mold the nation's health program". Who are these men? By what authority do they speak as experts? and why did they not authorize that their names be published in connection with their statements?

This Committee, speaking for the Medical Society, recognizes that the medical profession is subject to faults such as beset every profession or business in some manner or other. The Committee recognizes the need for and the value of constructive criticism, and therefore it has no desire at any time to disregard any justified complaints involving the practice of medicine in Rhode Island.

The members of this Committee claim no reportorial ability and the presentations that follow are an attempt at simple, factual explanation to the people of this State. They are not offered as arguments to perpetuate a newspaper controversy.

This Committee consists of the following:

Drs. Joseph C. O'Connell, Morgan Cutts, Charles L. Farrell, Peter F. Harrington, Earl J. Mara, Clifton B. Leech, Morris Botvin, Harry Hecker, Joseph W. Reilly, Charles J. Ashworth and Peter Pineo Chase.

* * * *

A Rhode Island physician relaxing at home with his family received an emergency call on a Sunday afternoon. A child was desperately ill. A hurried trip to the patient's home followed. The diagnosis —poliomyelitis. How long has the child been ill? "He was sick last Tuesday afternoon, Doctor, but we put off calling you thinking he would get better. He got worse Friday, and today he has been very bad." "Why didn't you call a doctor when the illness started?" No answer.

It is 11:30 at night. The ringing telephone of a Providence physician halted him in his preparations for bed. "Doctor, my wife has a pain in her abdomen. Has had it for three days. Can you come right over and see her?" Three days in which to check the cause of the pain during the physician's normal working hours.

It was a Wednesday afternoon when the emergency call brought a physician to an elderly patient's bedside. "We have been unable to reach our family doctor, and we are thankful that you have come."

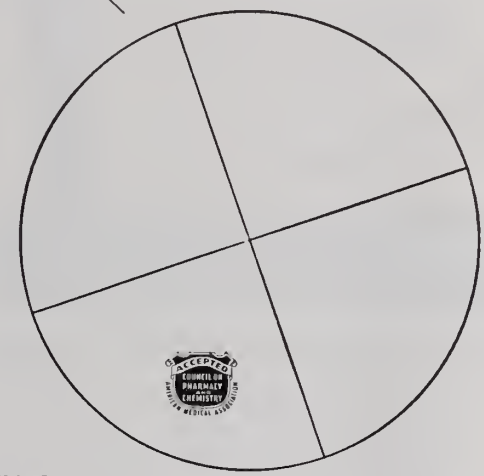
continued on page 514



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RHODE ISLAND MEDICINE

continued from page 512

The patient's illness — a heart attack, brought on by shoveling snow the hour previous. The family physician is later notified. His comment: "I have warned that man not to undertake any strenuous exercise or work because of his heart condition."

"Is the doctor in"?, the frantic telephone caller asks. "No, he is out on a call. Any message?" The receiver is dropped without further reply. The doctor's call: checking the condition of a drunken driver at the request of the police department in a city without an official police surgeon employed to answer all such calls. The result: a child injured in the neighborhood of the office of the physician is unattended until a physician from the other side of the city is reached and drives to the scene.

Nothing remarkable about these incidents to the physicians of Rhode Island. They happen regularly.

The remarkable thing is that in this compact, populous, and apparently well-informed and well-educated community some people suffer, and allow those about them to suffer anxiety, because they take good health for granted and do little to preserve it, because they ignore medical advice when it is given them, because they allow illnesses to develop to serious proportions before consulting a physician, because they apparently have little knowledge of the busy day of work for the average physician in general practice, and because they have become educated by press and radio advertising to try and cure all illnesses by self-medication.

Forget that the instances noted above are the so-called emergency cases. Multiply them by the hundreds of instances seen by physicians throughout the state and the country day in and day out in the regular course of their professional work. Instances of persons who disregard even the most common signals of pending ill health.

Instances of persons, who in spite of the nation-wide campaign for years to detect symptoms of cancer, hide a growth knowingly and then seek medical attention late.

Instances of parents who, in spite of the warnings such as that of the superintendent of health in Providence two months ago to guard against the increasing incidence of diphtheria by having their children properly immunized, will fail to act.

Instances of persons with a chronic ailment, even of the heart, who disregard the admonition to 'take it easy' and as a result bring on a totally disabling illness.

Instances of persons who believe implicitly the claims of 'quacks', faddist, and cure-all remedies, offered with little or no scientific proof.

The list is endless, as any physician will testify.

Every sickness and accident is an emergency requiring treatment. It is an emergency to the person incapacitated, and to his family. Such an attitude is perfectly normal, for we all know that we take good health for granted and any deviation from it is immediately disturbing mentally as well as physically.

But public opinion to the contrary, every sickness and accident is not a medical emergency requiring immediate attention by a physician.

In the course of any given day serious individual emergencies do arise that require medical attention, in some instance immediately. What the medical profession in Rhode Island has done, and is prepared to do regarding this type of emergency will be discussed tomorrow.

II

The *Evening Bulletin* in its articles on American Medicine stated that doctors as a group have failed to do anything about individual emergency medical service in Rhode Island, and about staggering their weekly days off.

But what are the facts locally?

As far back as 1943 the New England Telephone & Telegraph Company, and the Providence Police Department, were furnished lists of physicians who would be available for emergency medical calls in the Greater Providence area. Both agencies were asked to distribute the list throughout their subdivisions in order to provide night operators with a roster for calls requiring immediate attention. The physicians and surgeons telephone exchange was given the list also. In subsequent years lists numbering as many as 42 physicians for night emergency calls were checked for the telephone company.

In addition, since persons calling at night are alarmed and make separate calls for several physicians without informing each that others have been called, the following practical questions were suggested as helpful in checking the emergency calls: Who is your family doctor? Have you tried to reach him? If he can't come, has he referred you to any other doctor? Have you called anywhere else for a doctor? What result? What is the trouble — a cute illness or a chronic one?

What are the Emergencies?

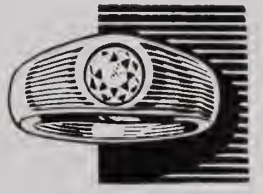
To get some idea of the individual emergency night calls from 7 p.m. to 7 a.m., let's take for an example a tabulation for an eight month period by a large local physicians telephone exchange.

A total of 601 calls were reported. This is an average of 75 a month, or 2½ a night, for a population of more than 250,000 persons.

Of these 601 calls 126 were not covered for the following significant reasons:

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Men's Diamond Rings

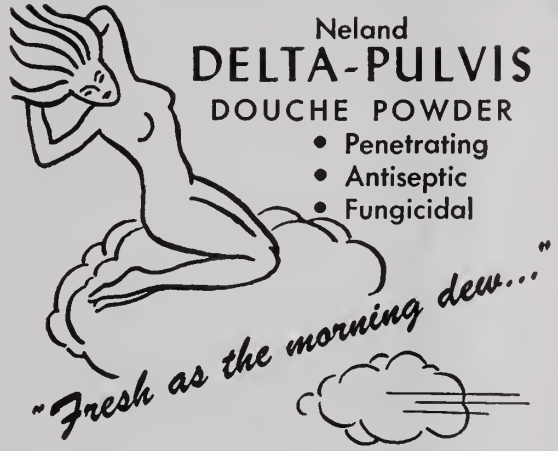


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51 persons, after discussing the problem, stated that they could wait until the morning to see their own family doctor.

31 persons were referred directly to hospitals.

15 decided, on reflection, that a doctor's visit would not be necessary after all.

14 wouldn't give any information.

15 were for alcoholics or drug addicts, or were cases requiring police investigation first.

Thus it is evident that the question of individual emergency night calls has not been neglected by the medical profession as a group. On the contrary, efforts are continually being made by the various district societies to guarantee that every real emergency is covered by a physician. The procedure adopted in Kent County was outlined by the President of the medical society there in a letter to the editor published in the *Providence Sunday Journal* of May 30. In Pawtucket a doctor's telephone exchange has been in operation for months and through it emergency calls are accepted.

The Providence Medical Association has been studying a plan for a central telephone exchange under the control of the Association for the physicians of greater Providence. This project will represent a sizeable cost. It will require a specially trained staff for 24-hour duty, and an office centrally located to warrant use of the exchange by doctors in all parts of the city. It will also seriously affect the present privately operated exchanges. These problems undoubtedly can and will be solved. The establishment of such an exchange will allow the Providence physicians to perfect a system under their own jurisdiction to cover all individual or group emergencies.

In providing this service the medical profession has a right to demand that it shall not be abused in any manner that can be prevented.

What about Doctors Free Days Off?

Much has been said of the difficulty in securing a doctor on a Wednesday. We question the difficulty of securing a physician on an afternoon, whether it is Wednesday or any other afternoon. The majority of physicians leave word at their home, or at a telephone exchange as to where they can be located if they are needed in an emergency.

A free afternoon or evening for the doctor, whether it is Wednesday or any other day, is merely a respite from his regular schedule of office hours. However, his telephone is covered by his home or a telephone exchange, and messages can be relayed to him even if he happens to be attending a hospital staff meeting, a medical meeting, or a performance at a theater.

Medical service is not limited by a work week, and Sunday is not the day of rest for the doctor that it is for most of the population. Hence, traditionally doctors have broken their week by taking Wednesday afternoon off. However, in recent years this situation has been altered, and every effort is being made to encourage members of the Rhode Island Medical Society to stagger their days off so as not to overload the men available for calls on Wednesday.

During the past year new members of the Rhode Island Medical Society have been asked to take other than Wednesday as a free afternoon.

Last November the House of Delegates, policy making body of the medical profession in Rhode Island, urged each district society in the State to develop a plan for the staggering of afternoons off by members of its society for the better protection of the public.

The Providence Medical Association, the largest district medical group in the Society, subsequently polled its membership asking for names of men who would shift their free day from Wednesday. The first results of that poll was published in the April issue of the Rhode Island Medical Journal, which is available to anyone, when the names of physicians transferring their free afternoon were listed.

As another step towards aiding the public to know what day doctors are not available in their offices, the Rhode Island Medical Society has already planned when publishing its annual roster of members later in the summer to include a listing of the individual doctor's free day. This roster, as in the past, is available to any reputable agency prepared to use it in the interests of the public.

We believe that the public, once it is sufficiently informed of the problem, and is educated to procedures that should be considered when emergencies occur, will cooperate in the same manner in which it did during the war years when medical care was necessarily rationed. Certainly the carrying out of some of the following recommendations will contribute immeasurably to the improvement of the local situation.

1. Have a family doctor who will know you, be familiar with your health needs, and be pre-

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pared to assist you at all times. Even persons who are presumably well should undergo a physical examination at least once a year. Use this opportunity to establish contact with a doctor, possibly in your own neighborhood. Find out from your family doctor how you can reach him when you need him and whom you can call when he is not likely to be available.

2. If the ill person has a temperature, or serious pain in the afternoon, don't wait until late in the evening before calling the doctor. A person really sick early in the evening is likely to be the object of greater concern from the family in the still hours of the night. Get the doctor early, for his and the patient's sake.
3. The emergency that demands instant care is rare. Don't be unduly alarmed if you do not contact your doctor immediately. If the call cannot be relayed to him — and most calls can be relayed through the doctor's office, home, or telephone exchange — call the second doctor on your list.
4. If medical services are not available immediately in an extreme emergency, take the patient to a hospital, utilizing hospital ambulance or police car assistance if transportation cannot be provided otherwise.

III

Specialization is one of the characteristics of modern life. We have specialists in advertising; specialists in salesmanship; specialists in manufacturing; specialists in play, and specialists in almost any line of endeavor that might be mentioned.

Is it any wonder, then, that in medicine, a field in which knowledge has been advancing so rapidly that no one man can any longer keep pace with it, that there should be specialists?

The statement by the *Evening Bulletin* that "specialization is the triumph and the bane of American Medicine" is contradictory.

Specialization has been a natural development in medicine. It has not been created as a means of bettering the lot of certain doctors. Its sole purpose is to provide better medical and surgical care to the public. Everyone has become increasingly conscious of the extent to which modern scientific research has broken barriers to the previously unknown facts in disease control and prevention. The public continues to expect steady improvement in the protection and preservation of life to the point where it now demands a greater and more specialized quality of medical care.

What has been medicine's problem resulting from this demand?

It is twofold: how to continue to provide the best medical care in the face of increased demands upon such specialized knowledge, and how to hold down an unavoidable cost factor in the supplying of the specialized service.

The pressure of both these complex factors offers a threat of making medical practice spread itself so thin that quality everywhere may be lowered. So far such deterioration has been avoided through specialization.

The creation of the Specialty Boards is one way by which medicine has sought to assure the public that the physician holding himself forth as a specialist in a definite phase of the healing art is qualified. The purpose of these Boards, of which there are but 15, is to direct the training of young doctors by requiring them to complete a minimum course of advanced study in addition to medical school and hospital intern training. This advanced study for specialty rating may require up to five years; usually a minimum of three years.

Even after completing his studies the doctor is not automatically entitled to specialty rating. He must first pass an examination given by the Board for the particular specialty in which he wishes to practice exclusively, such as anesthesia, obstetrics, pediatrics, surgery, eye, ear, nose and throat, etc.

How Many Specialists Are There?

The *Evening Bulletin* has stated in its articles that "there are today nearly 60 specialty societies,

continued on next page

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and close to 50,000 American physicians who call themselves specialists."

The Committee on Public Policy of the Rhode Island Medical Society corrects this statement.

First, there are only 15 Specialty Boards certifying physicians for specialty rating. There are in addition many state, regional and national societies of specialists which exist purely for educational purposes, but such societies have nothing to do with qualifying men or women as to specialty rating in medicine.

Secondly, statistics show that in 1947 there were but 28,476 physicians certified by the specialty boards — less than one-seventh of the total number of physicians in the country.

The Role of the General Practitioner

The increase in specialty work does not mean that the general medical practitioner is not as he always has been — the very backbone of medicine. He, too, has been benefited by the tide of specialization, and he is a part of it, and not apart from it.

Consider the great difference between the educational training of the family doctor of today and his predecessor. Medical education has been growing, courses of study have been extended, and years of internship training have been added. This background, coupled with his own experience and observation in the hospital, the bedside, and the office make him the physician of first choice for every family.

Contrary to the opinions expressed by the *Evening Bulletin* medical schools have for years educated men well to be primarily general practitioners. There is even one school in New England —The Tufts College Medical School—which emphasizes the training of family doctors.

The struggle on the part of medicine to achieve an ideal solution for the problems that face it in meeting the demand for both specialty and general medical care should not be made greater by confusing the issue.

The criticism that the specialist is unavailable in an emergency, especially at night, is unwarranted. Whether he is the surgeon, the anesthetist, the eye specialist, the obstetrician, the radiologist, or any other, the specialist is available for emergencies within his field of concentrated work. You will find him answering the call to duty in time of emergency, whatever the day or hour.

Nothing can suppress the trend toward specialization which has been a natural outcome of increased medical knowledge and techniques designed for the protection and preservation of health. Doctors are aware of the need for changes in the distribution of medical care. However, no immediate increase in either educational facilities or the

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number of applicants for medicine is possible. Present studies indicate that long term planning can and will accomplish this end without interfering in any way with the present high level of medical efficiency.

The writer of the *Evening Bulletin* articles on American Medicine thinks that the solution of the entire problem lies in "high quality group practice." What he fails to realize is that there are certain fundamentals governing the practice of medicine of which we should never lose sight. Foremost is the indisputable fact that medicine is an art and not an exact science, no matter what radical advances are made in science.

This will necessarily be so because there is an art in establishing prompt obedience to directions; in obtaining the wholehearted cooperation of a patient; in imparting and in having adopted useful information and instructions; in winning the confidence of frightened children; in understanding comprehensively the discouraging problems of the aged while sympathetically ministering to them; in entering strange homes and inspiring confidence in one's ability to cope successfully with any illness that has occurred. The art reaches its height in comforting as well as prescribing.

It was the practitioner of the art, and not the scientific laboratory, who discovered vaccination, who first ventured to use ether for a surgical operation, who introduced digitalis in the treatment of heart disease and who discovered insulin for diabetes.

IV

In discussing the costs of medical care the *Evening Bulletin* stated that "most of the millions of Americans who do not receive adequate care fail to get it for the simple reason that they cannot pay for it."

Generalizations such as the one above can be made about housing, nutrition, education, sanitation, or any other phase of better living.

What is adequate medical care? As implied by the *Evening Bulletin* it is the utilization of every available medical and allied health service regularly for every person, even to the extent of "x-rays, blood chemistry, a gall bladder series, kidney and liver function tests, metabolic rate tests, and others that modern medicine has devised."

The author of the articles on American Medicine suggests that every one of the millions of persons in this country requires all such medical services annually, or oftener, and he assumes that these procedures are routine for "adequate" and "decent" medical care.

continued on next page

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No physician believes that. We hope that few persons accept any such viewpoint.

Why? Because adequate medical care cannot be generalized. It is an entirely different problem with each patient. For one person certain tests may be imperative to aid in determining the existence of an organic disability. For another person there may be no indication prompting the physician to conduct laboratory tests. A third person may refuse to accept the diagnosis of his physician as final and request additional laboratory tests regardless of expense.

But for the patient to request, or for the physician to give, all, or the majority of the tests when there is no indication for them in the routine physical check-up is merely to increase the cost of medical care unnecessarily. An annual physical examination by the family physician is not beyond the economic reach of anyone. For the majority of the population the cost would be no more than the prevailing fee for a regular visit to a physician's office.

Cost Factors

Professional fees for medical care have varied little through the years and have not increased in proportion to the rise in the general cost of living. Yet the physician is faced with increased expenses in rendering services to his patients. There is no ceiling on the cost of the supplies, equipment and personnel he must utilize. For example, bandages which cost $6 a gross a year ago, now cost $24. X-ray films, instruments, and other supplies have increased in cost. Likewise, salaries for office nurses, secretaries and technicians have been raised.

Criticism has been made of physicians' prescriptions for medicines. Most often the specially trademarked product is superior to the minimum required by the pharmaceutical standards. A prescription from the physician is an *order* to the pharmacist who is a professionally trained man skilled in compounding drugs. The pharmacist has the responsibility of certifying the accuracy, the potency, and the safety of the preparation.

The person who buys the twenty cent box of laxatives takes all the responsibility for the use of his purchase. There is no guarantee as to the dosage, quality, purity, freshness — other than as stated on the package label — or as to whether it is the proper medication for the particular ailment for which it is purchased.

Good drugs properly compounded are just as wonderful in their own action as the "wonder" drugs of penicillin and sulfa, and their cost is proportionate, not excessive.

Are Specialists Fees Excessive?

Modern procedures and techniques in health care and health preservation, new drugs processed at great expense, increased use of hospitalization services — all contribute to the cure and control of disease. All claim their sizeable proportion of the overall cost of rendering medical care to the individual patient. These factors must be borne clearly in mind when appraising the fee for the physician's services. The specialist's fee is naturally somewhat higher because of his restricted practice and his more lengthy training.

The *Evening Bulletin* has stated that some specialists give a patient a "run around". It illustrated its case by stating that the patient "goes to a heart man and is sent to a stomach man, who looks him over and bounces him on to the lung expert (and) in each case he pays a substantial fee."

Occasionally there is a patient who requires the service of several specialists for complete diagnosis and treatment, but such referrals are made only with the patient's welfare in mind.

Specialization has resulted in part from public demand for highly-skilled services in restricted phases of healing.

Writers for newspapers and magazines have often over publicized in sensational manner medical and surgical techniques still in the process of development. As a result many a patient is misled into by-passing his family physician and heading directly to the specialist's office — with definite ideas of his own regarding his sickness and treatment.

Too often the patient incurs, on his own, expenses for services for which he has no need. A visit to his family doctor, who in turn is prepared to refer him to the proper specialist if special service is necessary, would often be more economical.

Free Medical Service

The medical profession of Rhode Island has never failed in its obligation to render medical care to the people of this state. To our knowledge no person in Rhode Island, regardless of his financial status, has been denied care.

There is no stigma attached to any free medical service rendered privately or in the hospitals of this state. That free medical service of tremendous cash value is given is shown by the record of Rhode Island Hospital for 1947.

Let's look at this record. Remember that each outpatient department visit is equivalent to an office call and the modest charge of $2 is used; that each ward patient was seen by at least one visiting staff man daily, and therefore the patient days charged at $2 gives a minimal value on this time by the visiting staff; and that for the final value 60% of the ward admissions in surgery at an average fee of $50 per surgical operation was used.

Look at the total of free care by the Rhode Island Hospital staff alone—

Outpatient department visits	54,728 @ 2.00	$109,456.00
Ward patient days	95,679 @ 2.00	191,358.00
Surgical ward care	3,703 @ 50.00	185,150.00
Total		$485,964.00

Multiply this contribution proportionately for all the other hospitals in Rhode Island, and America, and you gain some idea of the free public service rendered by the medical profession.

V

Did you know that insurance for surgical operations in Rhode Island will be available to employed groups of twenty-five or more through their employer on a cost-sharing basis under which the employee would contribute only 10 cents a week for himself, or 35 cents a week for himself and his family, under one of the policies approved by the Rhode Island Medical Society for its new surgical insurance program?

Did you know that another policy to be offered under the plan will be available to groups of five or more employed persons at 75 cents a month for an individual, and $2.50 a month for an entire family, and if additional protection is wanted for medical expense when a person is hospital confined and no surgery is performed, it can be bought for only $1 a month for an entire family, including man, wife and children?

The *Evening Bulletin*, in discussing voluntary prepaid insurance plans in its series on American Medicine quoted "expert observers outside the State" relative to the Rhode Island surgical plan to the effect that "its premiums are higher than they would need to be under a non-commercial setup."

We are certain that these "experts" did not have detailed information of the Rhode Island Surgical Plan.

There is no significance to the fact that Associated Medical Care Plans has not approved the Rhode Island Plan. That organization only passes on programs that are *exclusively* non-profit in their setup. The Rhode Island Plan is not even eligible for consideration as it includes both non-profit and profit organizations. Since the members of the Rhode Island Medical Society have endorsed the local plan, approvals by other organizations will add little.

The Rhode Island Medical Society has clearly stated that it will welcome Blue Cross as an insuring agent on the same basis as the Metropolitan Life Insurance Company, the John Hancock Mutual Life, the Equitable Assurance Company, and all the other insurance organizations supporting its program. There is no lack of cooperation upon the

continued on next page



"The General Practitioner Can Relieve 3 out of 4"

One acute researcher has noted that the odor of frying bacon causes emptying of the gallbladder in some subjects.

1 Gallbladder emptying is better stimulated by bacon's traditional companion-in-the-pan, the egg; the yolk preferred, and of course, unfried. Butter and cream do as well.

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That's what happens when we as a people commit ourselves to a single plan, whether it is administered by government or a private monopoly.

That's why the Rhode Island Medical Society has come forward with its new prepaid voluntary surgical plan which is now being copied in several other states in the country. We want every insurance agency, whether it is profit making, or non-profit-making — and of the seven largest companies active in group health insurance in this country *five* are mutual companies which under the law cannot make a profit — to compete so that the people of this state will have a choice of plans.

We all know that competition in business is the major factor in keeping costs down, and in providing the purchaser with more attractive products.

Here is a summary of some of the highlights of this Rhode Island Plan:

1. Thirteen large insurance companies — including the Metropolitan Life—are actively backing the plan.
2. Competition will provide the lowest premium rates for any surgical insurance plan sponsored by any medical society in the country.
3. Employed groups as low as five can be enrolled under some of the policies. Very few plans in the country have accepted such low group enrollment.
4. Dependents of employed workers may also be enrolled.
5. Immediate coverage is provided for both the individual and his dependents.
6. The number of operations that can be performed in any one benefit year is not restricted.
7. All types of surgical care — from a boil, a foreign body in the eye, a cut requiring stitching, to the most extensive major surgery — is provided.
8. The surgery may be done in the hospital, the doctor's office, or the patient's home.
9. For the person without dependents earning less than $2,000 a year, and for the person with dependents earning less than $3,000 a year, the policy payment covers the complete surgical cost. For persons above these incomes the policy provides cash payments ranging from $5 to $150, according to the operation, towards the physician's fee.
10. Every policy holder gets additional liberal payments towards the cost of anesthesia, blood or plasma transfusions, and for the services of an assisting physician.
11. Approximately 600 Rhode Island physicians have agreed to support the plan, and to accept the insurance payment as full fee for persons in the income groups.
12. The policy holder is protected under most policies for a limited period following the expiration of his insurance coverage.
13. There are no waiting periods, such as exist in plans in most states, for surgical operations on tonsils, adenoids, hernias, hemorrhoids, etc.
14. Provision is available under some policies for immediate coverage for obstetrics.
15. All non-occupational injuries for which compensation is not paid under the workmen's compensation law are covered.
16. Every policy is approved by the State Insurance Commissioner, and must also meet the specifications established by the Rhode Island Medical Society.
17. There is free choice of physician. However, only those members of the Rhode Island Medical Society who have signed as participating physicians are obligated to accept the insurance fee as complete payment for those persons in the income groups.

If there is a medical society sponsored insurance plan in America that offers more than this to its subscribers, and at costs comparable to those being set by the various companies underwriting the Rhode Island Plan, we have yet to see or hear of it.

What About the Above $3,000 Group?

The $3,000 family income limit for the service feature of the plan is the one generally accepted throughout the country by all the non-profit plans. Until experience in Rhode Island determines otherwise, our plan is employing that limit. How will it



The Alkalol Company, Taunton 12, Mass.

work out for the person with dependents whose family income is above $3,000?

Suppose, for example, Joe Doe makes $3,500 a year. He is married and has three children. He has an acute attack of appendicitis, is hospitalized and operated upon. If he has Blue Cross insurance he gets $7 a day towards his hospital bill, but he pays any additional charge for semi-private or private room accommodations, and for x-rays.

If he has an insurance policy under the Rhode Island Plan he gets for this operation

(1) an allowance of $20 towards the fee for the anesthesia given by a physician
(2) an allowance of $15 towards the expense of a surgical assistant
(3) an allowance of $100 towards the surgeon's fee.

Let's suppose the complete charges for the services of the physicians are $185. Joe Doe gets $135 from his insurance company and he has the balance of $50 to pay himself. That isn't a sizeable amount, but it might be under unusual circumstances, if, for example, Joe Doe has had a recent death in his family, financial reverses in business, or illness of his children. He can still discuss the problem with his physician as he does now.

Suppose Bill Smith whose income is in excess of $3,000 honestly believes that he has been charged an excessive fee for an operation? What can be do about it?

If such a situation arises, Bill Smith can take his problem directly to the medical profession, for the Rhode Island Medical Society has set up a Health Insurance Committee of physicians which, among other things, will act upon any complaints of persons insured under the plan.

The Rhode Island Plan is a good Plan. The doctors believe they and the insurance industry of this country can make it a successful contribution to the social security of the people of this state.

VI

Rhode Island doctors, as well as doctors throughout the country, are opposed to governmental control of the practice of medicine.

Doctors are not afraid of "socialized medicine." On the contrary they have done more to socialize medicine than has any other group.

Consider medicine's part in public health work—city, state and national. Here in Rhode Island the doctors of Providence fought for a city health department nearly a hundred years ago. They have continued such leadership ever since in promoting health care. Consider what doctors have done in municipal and state hospitals, like our Chapin Hospital, the institutions at Howard, and Wallum Lake. Doctors have socialized school health programs,

continued on next page

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service to welfare departments, industrial programs, and many others.

The term "socialized medicine" is often used to obscure an issue. Doctors have misued the term themselves when they were actually referring to federal or political control of medical practice.

Let's be clearly understood, then. Doctors in Rhode Island are not only opposed to political control of medicine, but we will resist it because it represents a system that not only will not, but cannot, live up to the glittering promises made by its proponents; because it represents centralized bureaucratic control at its worst; because it would be far more costly to the people of this state, and every other state, than the present system; because it would contribute little or nothing to improve health; and because it would lower the quality of medical care which, on the other hand, doctors continually seek to better.

Not Alone in Fight

The proponents of universal federally-controlled health service through payroll taxation claim that some Americans in some parts of the country who now get little or no medical attention would get some under their plan. But even the people in the rural areas of America, who presumably are faced with the major problem in the whole picture of medical care, are opposed to the idea of federal control.

Hear what the American Farm Bureau Federation representing 1,250,000 farm families said at its last annual meeting in opposing compulsory government health insurance:

> **"We are opposed to legislation designed to provide compulsory medical, health, dental, and hospital insurance. We recommend the full cooperation of rural people with our established health units and existing health programs. We believe the voluntary organizations of cooperative health associations will encourage people in need to take advantage of the services available for any medical or dental care which they may require."**

Not Insurance

The American people know what private insurance is, whether it is insurance on their life, health, home, or auto. If they don't like what one policy offers they can cancel it for another. The compulsory national health proposals are not that kind of insurance, if they are insurance at all.

The proponents for the nationalization of medicine, under such acts as the one proposed by Senators Wagner and McGrath, seek to create the impression that it would provide just a form of protection similar to life or hospital insurance, or any of the other kinds with which we are familiar. It would not.

It is a plan for Government administration of all medical care supported by a tax on payrolls and a Federal subsidy from taxes to cover the deficits. This is taxation and not insurance. It deprives the employee of his freedom of choice in spending the money he earns.

Staggering Costs Inevitable

What would it cost to carry out such a plan?

To operate the machinery required for a compulsory national health plan would take anywhere from 250,000 to 1,500,000 employees, in addition to the medical profession, and would involve tremendous political patronage. More than fifty million cases would have to be checked every year as a basis for payment and for statistical information. It is well-known that federal bureaus of this nature are notoriously inefficient and expensive.

The Wagner-McGrath compulsory health plan would claim 3 per cent of all earnings up to $3,600 a year, and additional appropriations equal to 1 per cent of taxable payroll. Add to that the 2 per cent now going into old age and survivors insurance, and the 1.8 per cent on an average that is paid for unemployment compensation. And in Rhode Island add in the 1½ per cent of all earnings up to $3,000 for the cash sickness act. This is the beginning; the end of the taxing isn't in sight.

Since it would be inexpedient to have either the worker or the employer bear the whole cost, the political planners would provide for a cost-sharing arrangement. Thus, from the outset a large and increasing sum would have to be paid by every tax payer already burdened with the costs of federal, state and municipal governments.

No Aid to Health Improvement

There isn't a bit of evidence presented to date to show that an overall tax plan for medical care would either give anyone more medical care than he is now receiving or at a less cost. Other countries with such programs have had no decline in sickness; on the contrary a steady increase both in the amount and length of recorded disability. Costs in such plans have mounted steadily and the quality of medical care has tended to deteriorate, for the incentive is soon lost by the physician who is no longer a free agent.

Compulsory schemes abroad are no models for America to follow. We have all seen in recent years evidences of the weakening of the freedom of the individuals in other lands because of the excessive dependence on government to solve their personal problems.

Reports of Experts

Two recent outstanding reports by experts in health and welfare contain conclusions that warrant repeating.

The National Health Assembly held a month ago in Washington point out that

"A medical care program itself will not solve the health problems of the nation. It must be coordinated with all efforts directed towards providing the people with adequate housing, a living wage, continuous productive and creative employment under safe working conditions, satisfying recreation and such other measures as will correct conditions that adversely affect the physical, mental and social health of the people."

The Brookings Institution, one of the country's best known and most reliable institutions in the field of social, economic and governmental research, invited by a Congressional committee to prepare a memorandum on medical care for the individual, stated among its conclusions that

"It is apparent that the United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country. This progress is now reflected in low mortality and morbidity rates of infectious diseases and in increased life expectancy. There is every reason to believe that these trends will continue unabated under our present system of medical care."

"The advances in health among both the whites and the non-whites that have been made in the United States in the past four decades do not suggest basic defects in the American system."

"The United States has some individuals and families not possessed of the resources to enable them to pay for adequate medical care. In the future, as in the past, provision must be made for them through public funds or philanthropy. The evidence suggests that many of them are elderly, impaired, or underendowed or are widows or deserted women or their dependents. It is doubtful if they could be effectively covered by compulsory insurance because they would lack the means to attain and maintain an insured status. The large majority of American families have the resources to pay for adequate medical care if they elect to give it a high priority among the several objects of expenditure. The issue is not whether they can afford medical care but whether they should be compelled by law to pool their risks and to give payment for medical care a top priority. The major alternative for people with ability to pay is to leave them free to determine for themselves what medical care they desire and whether they will pool their risks through voluntary arrangements."

VII

The world owes no one good health anymore than it owes him a living. One as well as the other depends on personal attention to individual welfare and is subject to the same variations.

As Dr. E. V. Askey, president of the California Medical Association, pointed out to the national conference of school and health educators last October, "the public should be educated to expect some amount of illness as a normal outlook, rather than to expect that good health is normal and that illness is something unusual."

The struggle for a healthy existence starts at birth. For some persons illness and disability are immediate; for nearly all they are inevitable sometime during life.

Medical care is but a part of the entire problem of health care. The United States Social Security Board pointed this fact out clearly, stating that "Health among a people depends on many factors other than medical care — among them, the amount and distribution of national income, the level of education and of sanitary safe guards, and climate and other environmental factors."

Doctors know how seriously good health is influenced by these factors. That is why they have always been active in campaigns to protect and preserve good health. Preventive medicine is only a new wording for what doctors have always preached and practiced.

From the days 60 years ago, when Dr. Charles V. Chapin urged improvements in hygiene and sanitation, citing problems involved in heating and ventilation of buildings, garbage disposal, filtra-

continued on next page



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tion of water, and disinfection techniques, to the present when doctors seek water pollution control, smoke abatement, and sanitary regulations for restaurants, the medical profession has led in fields of preventive medicine and health.

Personal Health Rules

Every person is the guardian of his own good health. The adoption of recommendations such as follow will help both the patient and the doctor to maintain and restore good health:

1. Don't wait for a serious illness before you ask your doctor's help. The earlier he sees you, the more he can do to help you avoid a major illness.
2. Have a family doctor who will know you, be familiar with your health needs, and be prepared to assist you at all times. Even persons who are presumably well should undergo a physical examination at least once a year. Use this opportunity to establish contact with a doctor, possibly in your own neighborhood. Find out from your family doctor how you can reach him when you need him and whom you can call when he is not likely to be available.
3. Tell your doctor the complete facts. A previous illness may not seem to you to have any bearing on your present condition, but to your doctor it might be a valuable clue.
4. If your doctor prescribes medicine, take it according to his directions. And remember not to use medicine prescribed for somebody else; your illness may be quite different however similar the symptoms seem to you.
5. If your doctor advises an operation, don't put it off. With modern surgery and modern hospital care, you seldom have reason to fear an operation.
6. The doctor knows all about new medical treatments through his own journals and scientific meetings, and they are not news to him when they are discussed in the popular press. If he does not recommend a new treatment for you it is probably because there is still some question of its value, some limitations not mentioned in the popular reports, or some reasons in your case which would make the treatment undesirable or ineffective.

The Cost Factor

Medical care is expensive, and it is becoming more expensive. But medical care is more than the services of the physician, it represents hospital costs, drugs and sundries, services of the dentist, and services of laboratories and persons skilled in special techniques. Each of these factors in turn is interwoven with the general economic pattern of the day. Thus, the rising cost of wages, supplies, food, equipment, etc., has its corresponding affect upon the cost of hospitalization, the physicians' services, and so on down the line.

What are doctors doing to assist in the distribution of the cost for their services?

For one thing, doctors have not raised their fees in proportion to the general increase in the cost of living. For another, they have worked out in most states, as we have in Rhode Island, a plan to provide for the prepayment of surgical operations by low cost insurance. Doctors have met the challenge of the times to provide the means for a voluntary solution of economic problems involving major medical costs; upon the public rests the responsibility to support the voluntary method of prepaid insurance, or relinquish its freedom in choosing its medical and other services to the federal government.

Rhode Island and the A M A

The *Evening Bulletin* has made reference to the control of the American Medical Association over the Rhode Island physicians. We correct this misunderstanding. The Rhode Island physician belongs first to his district or county medical society through which he has affiliation with his State medical society. All members of the Rhode Island Medical Society are automatically members of the American Medical Association.

The national association no more controls the Rhode Island Medical Society than the Federal government does the State of Rhode Island. The medical profession of this state act as they deem best for the people of this state, and never have they been restrained in any of their activities by the American Medical Association.

An outstanding example of this freedom of action is evidenced in the Rhode Island Plan—the prepaid voluntary surgical plan of the local doctors. This program, a new approach in that it utilizes both profit and non-profit insurance groups, cannot be controlled nor influenced in any manner by the American Medical Association, whether or not that Association likes the plan.

Facing the Future

We believe that the American people should build on the foundation of our present accomplishments. Our present plans for promoting health care have developed to the point that if expanded carefully and energetically they can provide much of the framework for the better national health which the American people seek and which they have a right to expect.

Real progress, however, requires more than technical knowledge and money. It requires resourcefulness and ability to work with initiative and determination. There is no easier way, though some persons think various forms of federalization

continued on page 528

PHYSICIANS DIRECTORY

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RHODE ISLAND MEDICINE
continued from page 526

offer a short cut. For all of us, physician and patient, there is a responsibility if we are to achieve better health, in Rhode Island as well as nationally.

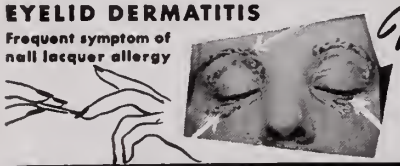
* * * *

The Committee on Public Policy of the Rhode Island Medical Society appreciates the opportunity accorded it by the *Evening Bulletin* to express the doctors' views on problems involving medical care in this state. It has presented its story in an effort to explain, and not to provoke any argument or controversy.

For the Society, the Committee expresses the request that any person in Rhode Island who may ever be denied attention by a physician report the incident with full facts to the Committee on Public Policy, The Rhode Island Medical Society, 106 Francis Street, Providence 3.

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Committee Appointments For 1948-1949

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Mrs. James C. Callahan	Newport
Mrs. Louis C. Cerrito	Westerly
Mrs. H. Lorenzo Emidy	Woonsocket
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Mrs. Charles L. Farrell	Pawtucket
Mrs. Herman A. Lawson	Providence
Mrs. Joseph C. Kent	Pawtuxet

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Mrs. Herbert E. Harris	Providence
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Mrs. Martin O. Grimes	Newport
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Mrs. Paul C. Cook, *Chairman* — Providence
(Remainder of the committee to be announced later.)

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MEDICAL LIBRARY NOTES

THE LIBRARIAN of the Rhode Island Medical Society announces the recent addition of the following books:

DAVENPORT COLLECTION

Louis H. Bauer—*Private Enterprise or Government in Medicine.* Springfield, Ill., 1948.

O'Donel T. D. Browne—*The Rotunda Hospital, 1745-1945.* Balt., 1947

George Crile. *An Autobiography.* Edited, with Sidelights, by Grace Crile. 2 vols. Phil., 1947.

Bernard J. Ficarra—*Essays on Historical Medicine.* N. Y., 1948.

John B. Wheeler—*Memoirs of a Small-town Surgeon.* N. Y., 1935.

GORMLY COLLECTION

Thomas A. Gonzales et al—*Legal Medicine and Toxicology.* N. Y., 1940.

ALLERGY

Warren T. Vaughan—*Primer of Allergy.* 2nd ed. St. L., 1943.

ANESTHESIA

Stuart C. Cullen—*Anesthesia in General Practice.* Chic., 1946.

Chauncey D. Leake—*Lethcon. The Cadenced Story of Anesthesia.* Austin, 1947.

J. H. Walton, editor—*Control of Pain with Saddle Block and Higher Spinal Anesthesia.* Summit, 1948.

CARDIOLOGY

George E. Burch & Paul Reaser—*A Primer of Cardiology.* Phil., 1947.

Emanuel Goldberger—*Unipolar Lead Electrocardiography.* Phil., 1947.

CHEST

Eli H. Rubin—*Diseases of the Chest. With Emphasis on X-ray Diagnosis.* Phil., 1947.

DERMATOLOGY

Kurt Wiener—*Skin Manifestations of Internal Disorders (Dermadromes).* St. L., 1947.

ENDOCRINOLOGY

Willard O. Thompson & Tom D. Spies—*The 1947 Year Book of Endocrinology, Metabolism and Nutrition.* Chic., 1948.

GERIATRICS

Wingate M. Johnson—*The Years After Fifty.* N. Y., 1947.

HISTORY OF MEDICINE

History of the Medical Society of the County of Westchester, 1797-1947.

HEMATOLOGY

Joseph M. Hill & William Dameshek—*The Rh Factor in the Clinic and the Laboratory.* N. Y., 1948.

MEDICINE

Russell L. Cecil, editor—*A Textbook of Medicine.* 7th ed. Phil., 1947.

George F. Dick et al, editors—*The 1947 Year Book of General Medicine.* Chic., 1947.

Robert P. McCombs—*Internal Medicine in General Practice.* 2nd ed. Phil., 1947.

Modern Medicine Annual—1947. Minneapolis, 1947.

MILITARY MEDICINE

Edwin C. Andrus et al, editors—*Advances in Military Medicine.* 2 vols. Bost., 1948.

DeWitt Mackenzie—*Men Without Guns.* Phil., 1945.

NEUROLOGY AND PSYCHIATRY

Edmund Bergler—*The Battle of the Conscience.* Wash., 1948.

Charles S. Bluemel—*War, Politics and Insanity.* Denver, 1948.

Louis S. London—*Libido and Delusion.* 2nd ed. Wash., 1945.

Israel S. Wechsler—*A Textbook of Clinical Neurology.* 6th ed. Phil., 1947.

OCCUPATIONAL MEDICINE

Health of Arc Welders in Steel Ship Construction. Public Health Bulletin No. 298. Wash., 1947.

OPHTHALMOLOGY

Ralph G. Hurlin et al—*Causes of Blindness Among Recipients of Aid to the Blind.* Wash., 1947.

OTORHINOLARYNGOLOGY

William L. Ballenger et al—*Diseases of the Nose, Throat and Ear.* 9th ed. Phil., 1947.

PATHOLOGY

William Boyd—*A Text-Book of Pathology*. 5th ed. Phil., 1947.

PHARMACOLOGY

Walter A. Bastedo — *Pharmacology, Therapeutics and Prescription Writing*. 5th ed. Phil., 1947.

PHYSICIAN-PATIENT RELATIONSHIP

Benjamin F. Miller—*You and Your Doctor*. N. Y., 1948.

Henry B. Richardson—*Patients Have Families*. N. Y., 1945.

POLIOMYELITIS

Collected Reprints of the Grantees of the National Foundation for Infantile Paralysis, vol. VII, 1946. N. Y., 1947.

RADIOLOGY

Charles A. Waters & Ira I. Kaplan, editors—*The 1947 Year Book of Radiology*. Chic., 1947.

SEX

Alfred C. Kinsey et al—*Sexual Behavior in the Human Male*. Phil., 1948.

SURGERY

Frederick Christopher—*Minor Surgery*. 6th ed. Phil., 1948.

Evarts A. Graham, editor—*The 1947 Year Book of General Surgery*. Chic., 1947.

TRANSACTIONS, REPORTS, etc.

Transactions of the American Association of Genito-Urinary Surgeons, vol. XXXVIII, 1946.

Transactions of the Association of American Physicians, vol. LX, 1947.

Transactions of the American Therapeutic Society, vols. XLV & XLVI, 1945-46.

Life Insurance Medical Research Fund, 3rd Annual Report, 1947.

Baruch Committee on Physical Medicine, Annual Report for April 1, 1945-December 31, 1946.

University of Pennsylvania. 31st report of the Henry Phipps Institute, 1944-1946.

Handbook and Directory of the State Medical Association of Texas. 1948.

Index to Current Periodical Literature On Neoplastic Diseases, July-December 1947. Gift of the Louisiana State Division of the American Cancer Society.

GIFTS

The Rhode Island State Library presented us with 111 bound volumes, 1 pamphlet and some unbound journals.



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BOOK REVIEW

WAR POLITICS AND INSANITY. By C. S. Bluemel, M.D. *The World Press, Inc.*, Denver, Colorado, 1948.

This book, written by a psychiatrist, has as its purpose, as the author states, the study of the "psychological qualities of political leadership and to identify the disorders of personality with which aggressive leadership is commonly associated". It is written for the layman in simple fashion in language that is understandable, in eleven brief chapters, 117 pages long.

The author discusses such topics as the causes of war, problems of leadership, and the psychodynamics of pathological leaders. He attempts to show analogy between human and animal leadership. He discusses the obsessive compulsive traits. He has a chapter on Psychiatry and History and a final chapter on The Future of Democracy, in which he outlines an idea for the more efficient management of democracy. Dr. Bluemel's analysis is not only on a very superficial basis but his use of psychiatric terminology is rather loose. He uses the term—obsessive compulsive trait—in a fashion that would signify both an abnormal and a normal characteristic. This is contrary to what is commonly accepted, for they are definitely pathological entities. He characterizes the accomplishments of people like Columbus, Peary, Florence Nightingale, Henry Ford, and many others, as possibly due to an obsessive compulsive trait.

The author feels that much of the difficulties in the world today are due to poor leadership, but he fails to explain how such men became leaders and he loses sight of the forces which produce this pathological type of leadership.

The plan that Dr. Bluemel promulgates for the improvement of democracy he describes as a "scientific one". In it he would allow only those of us who have a university education the privilege of voting and then only some twenty years after the university education had been completed. Need I point out that had we had such a plan our country would have been deprived of some of its greatest leaders. Furthermore, such a system would give us leaders who would represent only one group of people. They would have no knowledge or comprehension of the needs of a great segment of our population nor would they have the incentive to improve their lot. Virtually, it would lead to slavery of the disenfranchised. The author suggests that the plan is original. However, the writer feels that Plato outlined a very similar one some two thousand years ago.

DAVID J. FISH, M.D.

INDEX OF ADVERTISERS

	PAGE
Abbott Laboratories	473
Alkalol Company	522
E. P. Anthony, Inc.	497
Ar-Ex Cosmetics, Inc.	528
Arlington Chemical Company	519, 523
Ayerst, McKenna & Harrison	477
Bayview Convalescent Home	508
Blanding & Blanding	482
Borden Company	509
J. E. Brennan & Company	510
George A. Breon and Company	521
Joseph Brown Company	516
Butterfield Drug Stores	528
Camel	476
S. H. Camp Company	507
Ciba Pharmaceutical Products, Inc.	469, 503
Coca-Cola	531
Curran and Burton	528
Davies, Rose & Company	Inside Front Cover
Edgewood School	529
J. E. Hanger, Inc.	525
Eli Lilly & Company	Insert between 482-483
McCaffrey, Inc.	504
McKesson & Robbins, Inc.	471
Mead Johnson & Company	Back Cover
Medical Milk Commission	518
Merck & Company	479
Meredith & Clarke, Inc.	497
A. B. Munroe Dairy	506
Mutual Benefit Health and Accident Association	470
Narragansett Brewing Company	501
Neland Pharmaceutical, Inc.	515
Owens-Corning Fiberglas	505
Parke, Davis & Company	Inside back cover
Physicians Directory	527, 528
Rhode Island Limb Company	514
Rexall Drug Company	480
Schering Corporation	511
G. D. Searle & Company	499
Smith-Holden, Inc.	474
Smith, Kline & French Laboratories	513
Tilden-Thurber	515
U. S. Vitamin Corporation	472
Wander Company	478
Warwick Club Ginger Ale Co. Inc.	514
White Rock Bottling Company of Rhode Island	517
Winthrop-Stearns, Inc.	481

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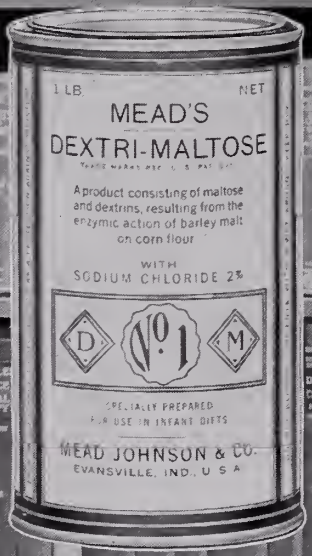
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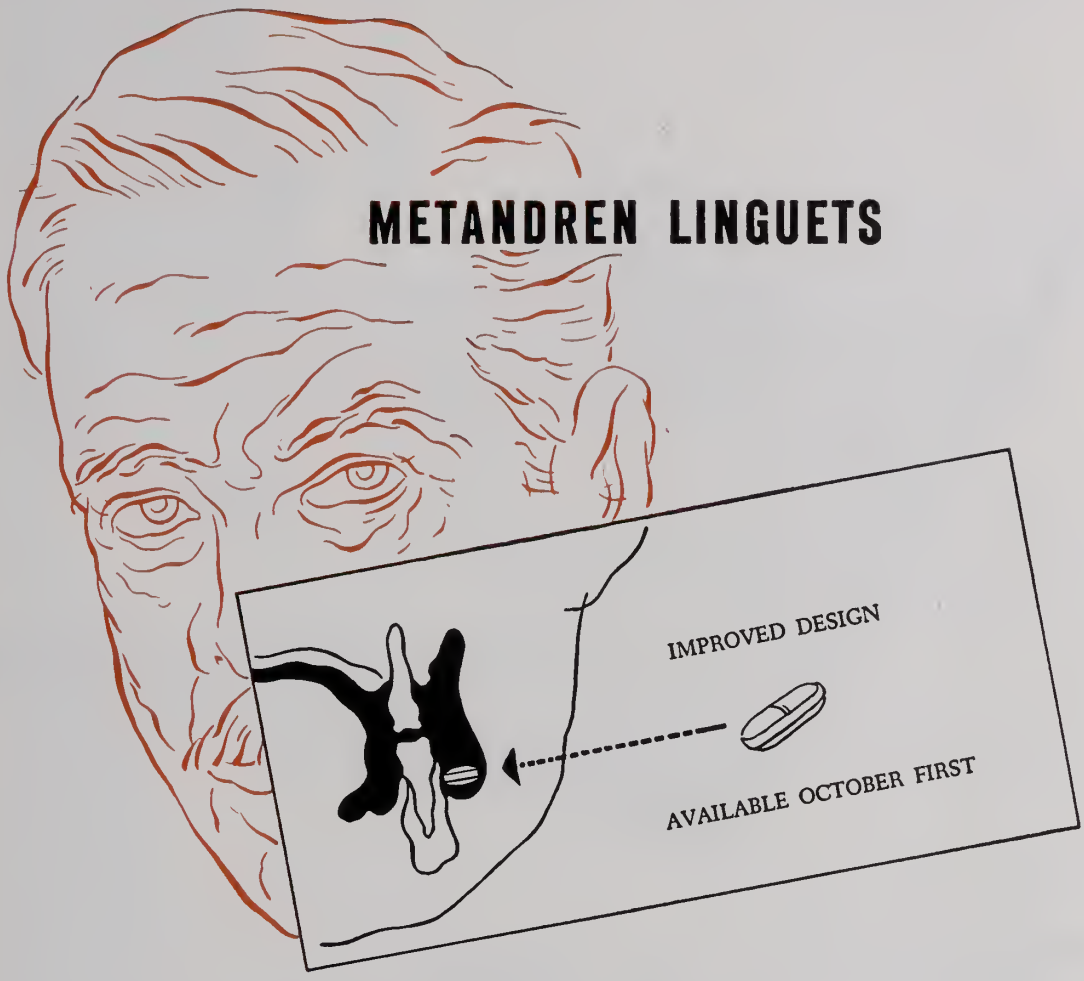
[1] Forbes, E. B., and Swift, R. W.: J. Nutrition 27:453 (June) 1944. [2] Forbes, E. B.; Swift, R. W.; Elliott, R. F., and James, W. H.: J. Nutrition *31*:203;213 (Feb.) 1946.

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1. Lisser, H.: *Calif. & West. Med.*, 64: 177, 1946.

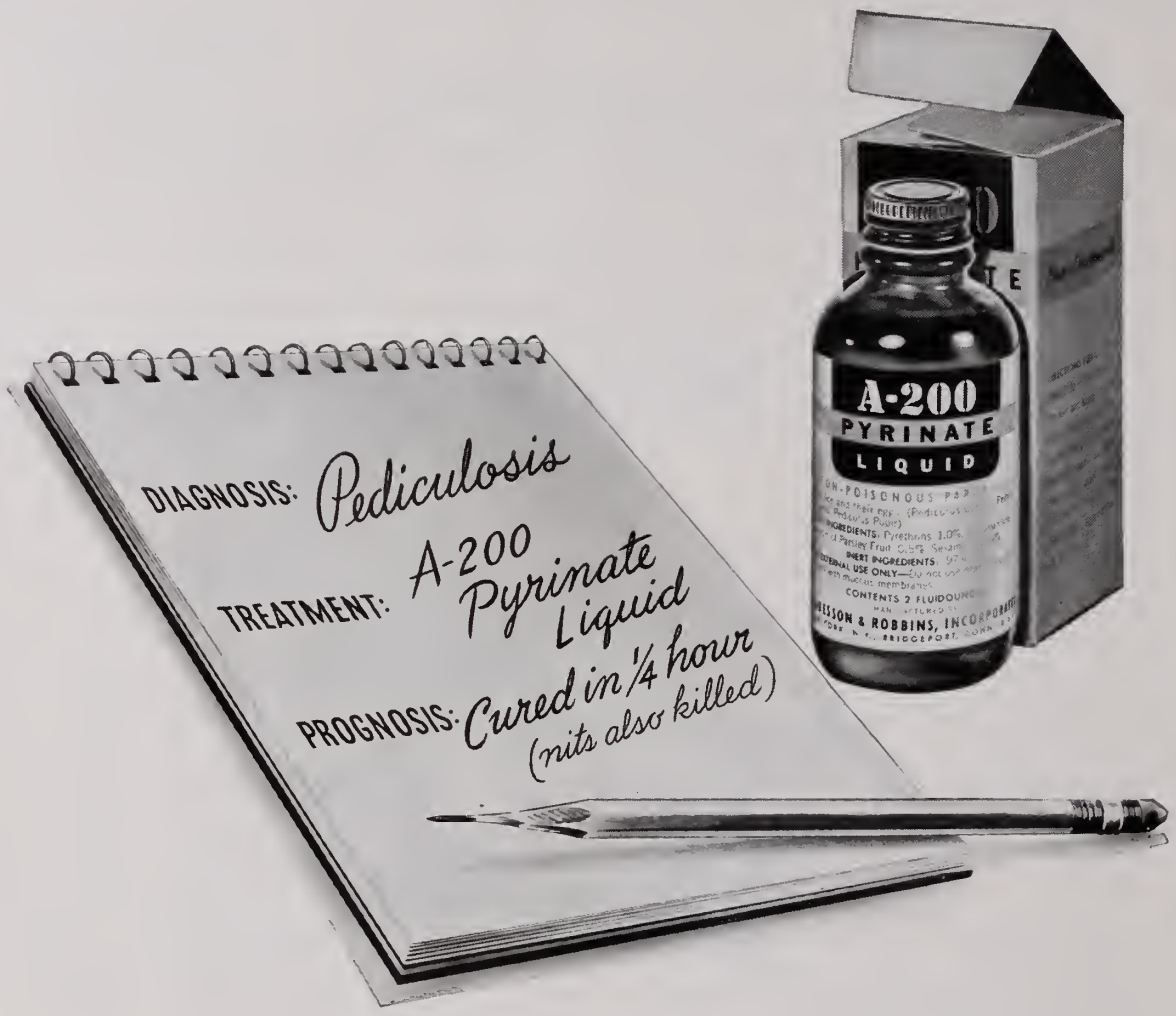
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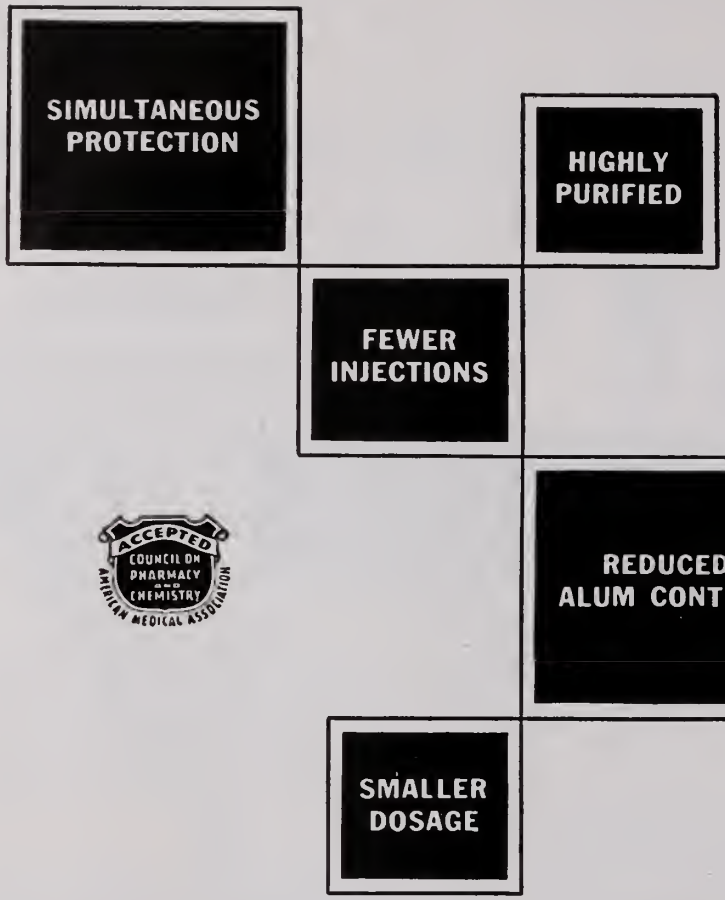
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1. Cartwright, G. E.: Blood 2:111 (March) 1947.

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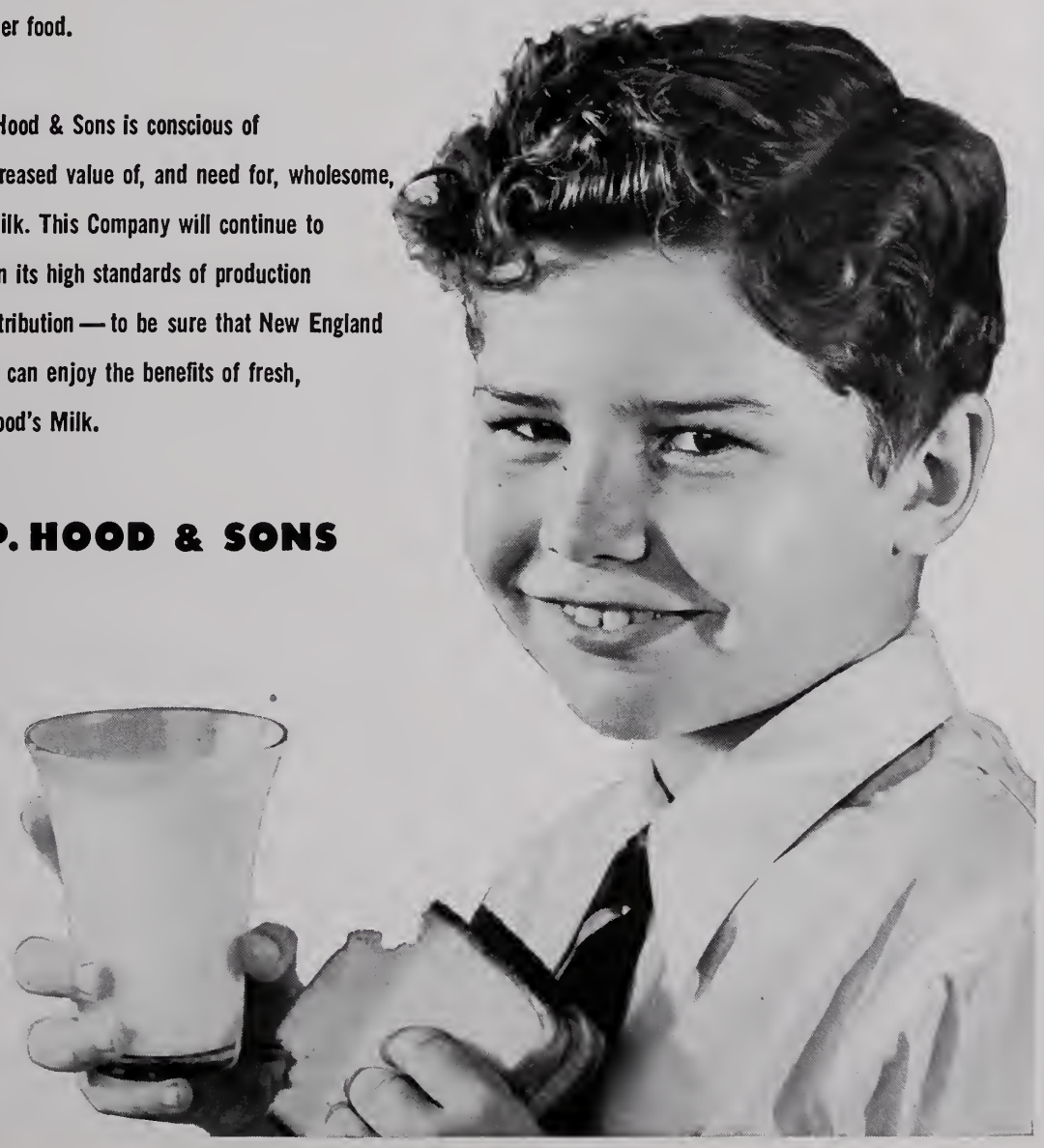
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Vol. XXXI, No. 9 September, 1948

TABLE OF CONTENTS

PAGE

Vesicovaginal Fistulae and Their Surgical Treatment, *Louis E. Phaneuf,* M.D. 547

Modern Health Programs, *Edward A. McLaughlin,* M.D. 550

Acute Ascending Paralysis (A Case Report), *Walter C. Weigner,* M.D. 556

The Doctor's Role in Community Programs, *Hugh R. Leavell,* M.D. 562

Discussion by *Robert O. Blood,* M.D. 566

Medical Statistics in Hospitals, *Mary Nunez,* R.R.L. 580

EDITORIAL

Social Insecurity 559

MISCELLANEOUS

Index of Advertisers 587

Return Siliform Ampuls 583

Wanted By The FBI 584

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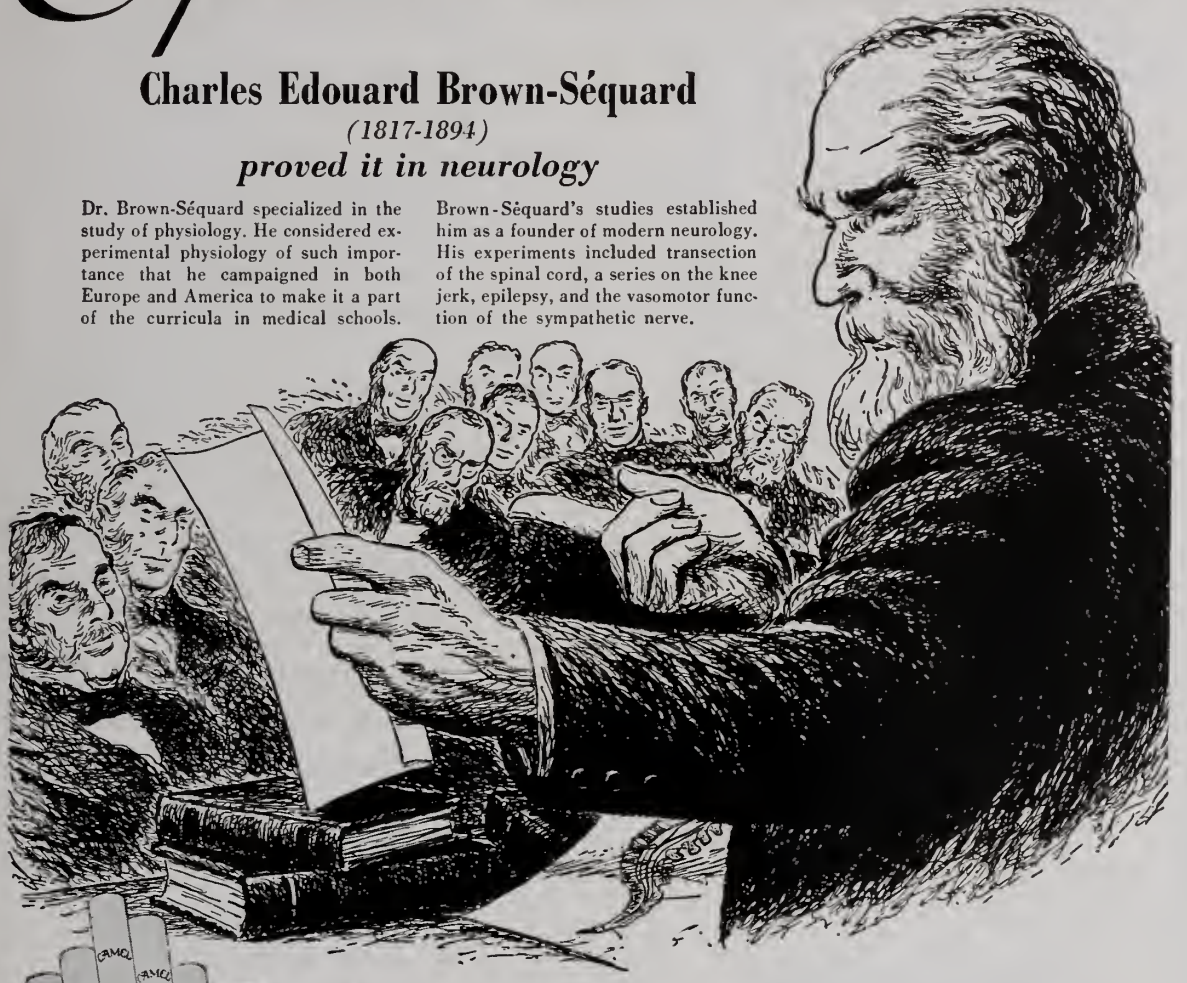
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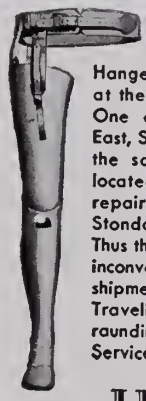
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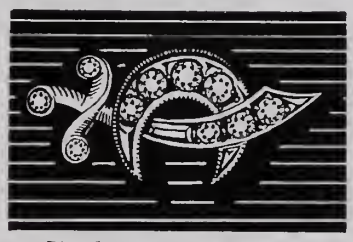
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The RHODE ISLAND MEDICAL JOURNAL

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VESICOVAGINAL FISTULAE AND THEIR SURGICAL TREATMENT*

LOUIS E. PHANEUF, M.D., SC.D., F.A.C.S.

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VESICOVAGINAL FISTULA is one of the most distressing maladies affecting womankind. Up to a little more than a century ago it was considered incurable. Before a cure was discovered, many women so afflicted begged to die because of their great suffering, but, as J. Marion Sims stated "Death would have been preferable, but patients of this kind never die; they must live and suffer."

In the days of Sims, a pioneer in the treatment of this condition, most vesicovaginal fistulae were the result of the trauma of labor. Women with contracted pelves and with feto-pelvic disproportion were left in labor for a number of days, not infrequently with filled bladders, so that with each contraction of the uterus the bladder was firmly pressed against the symphysis pubis by the advancement and retraction of the presenting part, usually the fetal head. Eventually sloughing of the bladder and vaginal walls occurred, which resulted in enormous vesicovaginal fistulae, and which frequently involved the entire base of the bladder.

In the days under discussion, before 1834, there was not a great deal that could be done at delivery; cesarean section, as it is known at present, had not been developed, and the method of abdominal delivery employed at that time was almost universally fatal, on the one hand, because of its crude technique, and, on the other, because it was never employed until the parturient was far advanced in labor and frankly infected. Most of the women were delivered with forceps and it was well that it was so, for a woman with a vesicovaginal fistula could survive, and, after a cure was discovered could once again become a useful member of society.

The employment of the forceps was blamed for the resulting fistula when, as a matter of fact, it was the withholding of the forceps rather than their use that was responsible for the infirmity. The obstetrical fistulae were large, but with proper instrumentation they could be readily exposed for suturing. With the improvement of obstetrics in general, and of delivery care in particular, during the last five decades, the large obstetric fistulae of the past are seldom encountered.

Because of the marked strides in gynecologic surgery during the last half-century, operations on the female pelvic organs are performed daily in most hospitals. As a result of this large amount of surgery in this part of the female anatomy, the urinary bladder, which is attached anteriorly to the uterus, is exposed to injury. Injury to this viscus occurs in three ways: first, by direct trauma at operation; second, by interference with the blood supply to a certain small area of the bladder, resulting in sloughing; and third, by including the bladder wall in the sutures that close the vagina in the performance of abdominal panhysterectomy, in the closure of the vagina in various vaginal plastic operations on the anterior vaginal wall, and in the operation of vaginal hysterectomy. Fistulae resulting from operative trauma appear immediately after operation, while those due to necrosis and sloughing do not become apparent until a number of days have elapsed. Syphilis, tuberculosis, carcinoma and foreign bodies, such as pessaries, by erosion and ulceration, may account for an occasional bladder fistula. The surgical fistulae which are more commonly met nowadays have increased the difficulty of closure because of their inaccessibility, since they are situated in a high scarred vaginal vault; yet by

continued on next page

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means of a Schuchardt incision a number are rendered accessible. As a general rule, the three types of vesicovaginal fistula most difficult to close are those that are adherent to bone, those situated in a high scarred vaginal vault and those in which there is extensive loss of tissue.

In this country, for many years, we have given credit for the first successful operation for vesicovaginal fistula to Sims. In 1849 he successfully operated on a slave girl, Anarcha, and closed her fistula at the thirtieth operation through the use of silver-wire sutures, which he believed he had invented. To achieve this result he had worked for a number of years at the expense of his health and his income, and was aided by the sacrifices of his family in order that he might achieve this great feat. But if we study the literature carefully and go back far enough, we find that in January, 1834, Montague Gosset,[1] a surgeon of London, successfully closed a vesicovaginal fistula with gilded silver-wire sutures. In 1839, George Hayward[2] of Boston reported in the *American Journal of Medical Sciences* a successful operation for the closure of vesicovaginal fistula. In 1851, George Hayward[3] of Boston reported in the *Boston Medical and Surgical Journal* two additional successful operations for vesicovaginal fistula. In May, 1849, as previously stated, Sims closed Anarcha's fistula at the thirtieth operation. In 1857, Sims[4], in an address before the New York Academy of Medicine, claimed the honor of the discovery of the silver-wire suture.

The successful cases of Gosset and Hayward should not detract from the painstaking work of Sims, except in so far as priority is concerned. It is doubtful that he knew about the case of Gosset or the successful case of Hayward in 1839. He should be given full credit for presenting to the profession a well planned operation and for inventing the instruments that made its performance possible. In other words, after Sims' contribution we had a planned operation: the position that he advised, originally the genupectoral position, then the Sims' position, and the instruments with which to perform the operation so that the average surgeon could carry it out.

Technique of Operation

Because of the many types and locations of vesicovaginal fistulae, numerous methods of closure had to be devised. As a general principle, these methods and their modifications are divided into five groups: (1) The vaginal procedures, including several varieties of technique; (2) the intravesical procedure, a modification of which is proposed by Phaneuf and Graves;* (3) the suprapubic extraperitoneal procedure, through a Pfannenstiel incision: (4) the intraperitoneal procedure through an abdominal incision, (Legueu technique); and (5) implantation of the ureters in the sigmoid, (Coffey technique) and its modifications.

The majority of these fistulae are closed by the first procedure, through the vaginal route; the other four procedures are reserved for the cases in which the vaginal method of closure cannot be applied. Since 1927, all cases of vesicovaginal fistula at the Carney Hospital are studied by both the Gynecological and Urological Services. We have combined our resources and have tried to choose the best method applicable to the given case.

Preoperative Preparation

After a complete gynecologic examination the patient is submitted to rigid urologic studies. The urine is cultured, and all infections are treated by the antibiotics and the sulfonamide group of drugs; the vaginal walls are treated by means of mildly acid douches, a 1:1000 solution of acetic acid, hydrochloric acid or nitric acid, which dissolves the phosphatic incrustations. The vulva and inner aspects of the thighs, which frequently show excoriation, are treated by means of 10 per cent silver nitrate solution and by a protective layer of diachylon ointment (Unguentum Plumbi Oleatis, N.F. VIII.)

The urine is acidified by means of ammonium chloride or other drugs, to prevent the further formation of phosphatic deposits. After the infection has cleared up a cystoscopic examination is carried out, the relation of the fistula to the ureteral orifices is studied and pyelograms are obtained. The operation is not undertaken until all infection and irritation have been overcome, and only when the operator is satisfied that the tissues are healthy enough to hold the sutures and that healing will take place.

Suprapubic Bladder Drainage

For the proper healing of a repaired vesicovaginal fistula, the bladder should be kept empty. In his first operation Sims tried to institute constant drainage by introducing a piece of sea sponge, to which a silk thread had been tied, in the urethra to the bladder neck so that urine would drain by capillary attraction. Infection set in, the temperature rose to a high degree and the patient was very sick. The operation was a failure. There followed the metallic catheter, then the present rubber catheter with all its modalities.

In the majority of cases constant bladder drainage is instituted through the urethra, the catheter being left in for seven to ten days. For the very difficult cases operated on vaginally we have found at the Carney Hospital that suprapubic drainage rendered great service. Since the bulb on the tip of

* The technique of this method will appear in Surgery, Gynecology and Obstetrics in the near future.

the catheter does not press on the suture line, healing goes on undisturbed, and the patient is more comfortable with this type of apparatus than she is with a urethral catheter. We continue the suprapubic drainage for twenty-one days. If the suprapubic catheter is brought out high up at the fundus of the bladder, the drainage tract usually closes in forty-eight hours after the catheter is removed.

Suture Material

Success had been obtained in closing a vesicovaginal fistula with silver-wire sutures when all other suture material had failed, because, as Sims explained it, silver-wire caused no inflammation and tumefaction in the tissues. In the days when the Sims operation was first performed, the edges of the fistula were pared or denuded of scar tissue and the bladder and vagina were brought together in one layer by interrupted sutures. These tissues came together with a varying amount of tension and had to be held together long enough for healing to take place. The silver-wire sutures fulfilled these desiderata. More recently, W. Wayne Babcock of Philadelphia, who had proposed the steel-alloy wire suture for infected wounds, advocated it also for vesicovaginal fistula. It has two advantages over silver wire: a smaller strand may be used and the suture may be knotted instead of twisted as is necessary with silver wire and it does not cause disfiguring argyria in the tissues. The improvement of surgery in general having been applied to the operation of vesicovaginal fistula, most operators today dissect the bladder free from the vaginal wall, and when the bladder and vagina have been freely mobilized the edges may be brought together without the slightest tension. For this reason many operators now close these fistulae with fine chromic catgut sutures in two or three layers, rather than with metallic sutures.

Postoperative Care

The postoperative care should be under the immediate supervision of the operator himself, and not left to less experienced young assistants. Except in the case of transplantation of the ureters careful bladder drainage should be instituted. This may be transurethral or suprapubic, the latter being reserved for the difficult cases. As previously indicated, the urethral catheter is removed at the end of seven to ten days, and the suprapubic at the end of twenty-one days. The bladder is irrigated by warm boric acid solution as indicated, but no strong antiseptics are left in the bladder. Penicillin or sulfadiazine or both are given in adequate doses as a prophylactic against infection. Keeping the patient on her abdomen during part or all of the convalescence is a valuable procedure when drainage has been instituted through the urethra. When metallic sutures have been used they are removed at the end of a month, always under anesthesia, intravenous anesthesia being quite satisfactory. The patient is allowed out of bed the day after the constant drainage apparatus is removed, on the eleventh or the twenty-second day, depending on the type of drainage used, and she is discharged from the hospital on the twelfth or twenty-third day, as the case may be.

Summary

The history of successful operations for the closure of a vesicovaginal fistula is outlined. The etiology and the various methods devised to close the many varieties of fistulae are discussed. The preoperative preparation, the suture material and the postoperative care are taken up in some detail. The advantages of suprapubic drainage in certain difficult cases are stressed. The history of vesicovaginal fistula is a very interesting one. The successful closure of this lesion has restored a group of women to normal, useful lives, who before 1834 might otherwise have been doomed to lives of suffering and ostracism.

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MODERN HEALTH PROGRAMS*

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I FEEL PRIVILEDGED to have this opportunity to address my colleagues of the Rhode Island Medical Society and their guests at this 137th annual meeting. Your invitation to appear on the program and my presence here indicate that we have come to recognize the increasing importance of a closer relationship between public health and the practicing physician. Over the years there has been a friendly relationship between the Society and the State Health Department. Doctor Pitts, a former President of the Society has been most cooperative in assisting us in the Cancer Control Program. Dr. Ruggles has been a member of the State Committee on Nursing Education for the past twelve years and is now serving as a member of the Hospital Advisory Council. Doctor O'Connell, our new President, has been a member of the Board of Examiners in Medicine for the past seven years. Through these men and other members of the Society this friendly relationship has been formed. It is indeed a coincidence that the first speaker introduced by Doctor O'Connell the newly installed president should be a friend of long standing.

The title of my paper is "Modern Health Programs". Although the American Medical Association keeps its members well informed on National Health Legislation through its special bulletins, I know that there are many programs which are planned, put into effect, and well under way by State Health Department before the medical profession learns about them. Great strides have been made in Public Health Administration and public health activities by State Health Departments expanded and broadened in a comparatively short space of time. These changes have come about partly through Public Health Education but mostly by the encouragement given by the Federal Grants-in-Aid.

The medical profession has often misunderstood the purpose and objective of Public Health largely because fundamentally its basis seems different from that of medical practice. The latter has focused its eyes upon disease as it occurs in the individual patient while the Public Health physician is more concerned with the health of communities and the broader aspects of diseases, the morbidity and mortality rates, environmental protective measures, and the economic loss incident to disease. The early modern Public Health movement was founded upon the introduction of the laboratory six decades ago in the field of bacteriology with the resulting discovery of the etiological agents of the many infectious diseases and their mode of spread. It became possible to institute preventive measures such as water purification, sanitation and food protection, to usher in a new era in preventive medicine as well as curative medicine. With each new discovery in this virgin field of scientific endeavor the interdependence of the Public Health worker and the practicing physician has become more marked. This was especially evident with the advent of the Public Health Laboratory. The practicing physician would feel helpless without these diagnostic facilities and the aid thus provided in the control and treatment of infectious diseases. On the other hand without the active cooperation of the practicing physician the epidemiologist would be hindered in accomplishing the best results.

Previous to the year 1935 there had been two programs over the years when the Federal Government made financial grants to State Health Departments. One grant was for the purchase of drugs to be dispensed free for the treatment of Veneral Disease and another to promote Child Hygiene activities. These grants were not large and were made only for a few years. In 1935 the Congress passed the Social Security Act with many titles. Title V made allotments to states for Maternal and Child Health Services and Services to Crippled Children; Title VI made allotments to states for General Health work. This was the real beginning

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of Federal Aid for the advancement of Health Services to the states through their respective Health Departments. As the years passed appropriations were continued and allotments increased and as of this date without breaking down the figures into their respective categories such as Service to Crippled Children, Tuberculosis Control, Mental Health Services, Cancer Control, General Health unspecified, Industrial Hygiene, Maternal and Child Health Services which include Rheumatic Heart and Emergency Maternal and Infant Care, Venereal Disease and Dental Health more than 50 million dollars is being appropriated annually by the Congress for Health Services through Health Departments in addition to the 75 million dollars for hospital survey planning and construction. A recent accounting by the Federal Security Administrator of the Federal Funds allocated to the various states during the year ending June 30, 1947 for Health and Welfare Services reached the high figure of one billion 250 million (1,250,000,000.) with eighteen programs involved. The effect of this Federal stimulation on State Departments of Health can be well demonstrated by the following: A short thirteen years ago the Rhode Island Department of Health had its laboratory as an aid in detecting and ultimate control of Communicable Diseases; it had a Division of Maternal and Child Health with several nurses who carried on a program for health education for mothers and children and conducted a few well baby clinics; it had a Division of Communicable Diseases which made epidemiological studies of outbreaks of diseases including a venereal disease section which distributed arsenicals to the physicians of the State and attempted to check the spread of venereal disease; it had a Bureau of Vital Statistics which kept records of births, marriages and deaths. The budget of the State Health Department at that time was $130,000.00 and there were 50 full time employees. Although the State Reorganization Act of 1935 placed the functions of several commissions and boards that were functioning independently, in the Dept. of Health, nevertheless, these national health programs with their grants-in-aid were the main source in producing a greater expansion of the department and an extension of basic health activities. The State Department excluding the cost of operating the State Sanatorium at Wallum Lake, now operates on a budget of three-quarter million dollars with 172 full time employees. Of this, three-quarter million dollar expenditure the Federal Government contributes $400,000.00. While Public Health is primarily the responsibility of State and Local Governments the Federal share of this responsibility has been amply demonstrated through the passage of the Social Security Act and the increasing amount of Federal grants-in-aid that have been made available for Public Health.

The Emergency Maternal and Infant Care program to aid the wives and infants of men in the armed forces below a certain grade, during its existence authorized services for 1½ million individuals with the Rhode Island figure of 7500 aided. When this program was inaugurated I saw the possibility of the first inroad by the Federal Government in the realm of private practice of medicine. However, it received the approval of the AMA and apparently worked out well to the satisfaction of all. I have been informed that this program is about to be resumed. To date none of these programs with resultant expansion in Public Health activities has as yet, as far as I can see, made any inroads into the private practice of medicine. Whether or not some or all may be a foundation for and the experience derived in administering these programs provide the machinery or act as a wedge for the socialization of medicine, time will tell. I believe the vigilance of the State Health Officers all of whom are physicians and many of whom are active members in their State Societies has been responsible in preventing Government encroachment in the field of the practicing physician. There are some career men in Public Health who, never having been in private practice, and so, not having had the opportunity to familiarize themselves with the practice of medicine, may desire State control, but at the present time these are in the minority and the Association of State and Territorial Health Officers as a whole has been a watch dog against any programs that would interfere with the relationship between the patient and the private physician.

Last week at the request of the President, Mr. Ewing, Administrator of the Federal Security Agency, called a National Health Assembly for the purpose of developing a ten year program of health goals for our country. Some six or seven hundred leaders from all phases of our national life were invited with the aim of obtaining the widest possible presentation and the best possible advice. It may be of interest to you to know that the executive committee of this National Health Assembly consisted of forty members only five of whom were doctors of medicine and one a doctor of dental surgery. You have seen reports in the papers of the meetings held at the National Health Assembly with captions such as "Health Plan Snags Parley" and "Improved Medical Services Urged". Out of this Assembly with its many meetings will come the stimulation for more health programs which certainly will include medical care. I recently read in the Washington Report on the Medical Sciences that Dr. Hugh R. Leavell, of Harvard University School of Public Health had been chosen by Fed-

continued on next page

eral Security Agency to be chairman of the Medical care section. The announcement was made without waiting for AMA indorsement after several weeks of wrangling between AMA and FSA over the chairmanship had failed to fill the position. It went on to say that Dr. Leavell was reputedly a middle of the roader with respect to medical economics. Tactfully avoiding the expressing "health insurance," the FSA description of the medical care section's scope says, in part: "(It) will discuss the organization and financing of personal health services . . . the adequacy and potentialities of various plans and arrangements . . . for meeting current needs and steps to be taken toward making better health care available to the population". Early reports on results of the meetings of the National Assembly indicate that there is a definite agreement that some prepayment plan should be adopted for medical care; also great stress was laid on the need of trained personnel to carry on health services. Emphasis was made on the shortage of doctors as well as other trained personnel; the need of appropriation of greater funds for expansion of health services and I understand the only fireworks was Labor's attack on Doctor Fishbein.

Programs are initiated and stimulated by Federal grants and the day may come when the grant is out and services already demonstrated to be worth while must be curtailed unless the State provides financial aid to carry them on. If it does not it is the State and not the Federal Government that is criticized for curtailing the services. There is a slogan "Health is Wealth" and unless we have a healthy nation we cannot be a productive nation, but where shall the line be drawn? Shall the Surgeon who saves a man's life make the fee so large that the individual would live a miserable existence because of lack of funds to exist and shall the Federal Government with its many programs, health and others, make it possible for man to live longer and enjoy good health only to live unhappily by the taxes that are thrust upon him? Up until the present time it is apparent that the promotion of the Public Health has made it possible for our people to have good health so that they can work and earn and have money both to live well and to pay taxes. Most of these programs are planned by highly educated persons in the field of health, many of them lay persons and the propaganda, if we may use the term, from those sources has been responsible for the establishment of these programs, during the past twelve years in this socially minded country of ours.

There are two bills in Congress now under consideration neither of which I believe will pass nor be enacted into law. Both pertain to health insurance. The Wagner-Murray-Dingell Bill calls for compulsory health insurance which includes medical care and hospitalization or in other words for the over all medical care of all the people, supported by a nationwide tax collected by payroll deduction of workers in industry and other taxes on non-payroll citizens. Provisions are made for decentralization of administration and guaranteeing free choice of physician. The Taft Bill contemplates Federal grants to the several states and challenges the states to develop their own plans for taking care of the health needs of the people within their respective jurisdiction; no special earmarked tax is proposed under the plan. Since such funds do have to come from monies not otherwise encumbered, in the final analysis such monies would necessarily have to come from taxation. Senator Taft has lambasted the White House efforts to socialize and nationalize medicine and to pour billions in taxes into Washington but his bill provides for Federal grants to States for Medical care and would not that be a beginning of State Medicine although decentralized?

Last summer and fall Governor Pastore received several requests from the sub-committee of the Congress reviewing these proposed acts. He finally answered by stating that:

> "As we review the situation in Rhode Island we believe that all classes of the population are getting adequate medical care. Seventy per cent of the State's population is enrolled in the Blue Cross. The Rhode Island Medical Society is about to set in operation a surgical care program. The State Department of Health is about to complete its survey pursuant to the State's participation in the Federal Aid to Hospitals program. Since Rhode Island is a small State and all parts readily accessible, we have no widely scattered rural areas and consequently no health problem that cannot readily be taken care of. We feel that the health needs of the people in Rhode Island are being taken care of in a very satisfactory manner. In the over all national situation on this problem, we do not feel that we are in a position to make comment."

Surprising even Capitol Hill's most dogged followers of legislation was the decision last week by Senate Committee on Labor and Public Welfare to hold hearings on the Lodge Bill. Introduced by the Massachusetts Senator in February 1947, and amended by him three months later, the measure (S.678) had been all but forgotten. Its revival at this time is fraught with meaning. His party wants to put over a piece of major health legislation before Congress adjourns, being fully cognizant of its political value come November. They realize that the Taft and Murray-Wagner-Dingell bills have killed off each other. True, bills strengthening local public health units are pending before House and

Senate but these do not possess the potential vote-getting punch of S.678. This measure authorizes Federal Grants to the various states to make free medical services available "to such persons as may require them," regardless of their financial means. "Medical Aid" is defined as the more expensive therapeutic drugs (including biologicals presumably), X-ray and laboratory diagnostic services and respirators. Allocation of the Federal funds would be by U. S. Public Health Service but the states would have virtually unrestricted control over selection of patient-recipients. Senator Lodge first introduced his plan in 1940, revieved it last year and now hearings are scheduled before the health subcommittee of Senator Taft's Labor and Public Welfare Committee.

There is an act now being studied by a committee of the Congress termed the Local Public Health Services Act of 1948. This act presupposes people living in rural areas cannot have the same benefits of preventive medicine and other Public Health procedures as those who live in urban areas. We all agree that the knowledge now possessed for the promotion of good health should be made available to all people, and again it is argued that the Federal Government should assist in providing for the health of the people since the people's health is the nation's greatest asset. We in Rhode Island have no rural areas when the national picture as a whole is considered. The Hospital Advisory Council has agreed that in dividing Rhode Island, under a formula set forth in the Hospital Construction Act, that there is no area that can be considered rural. Rhode Island is a small State and all parts readily accessible to hospitals, health centers, and private physicians. It is interesting to note that the State of Vermont in its plan for construction of new hospital facilities and health centers does not consider itself as having rural areas under the definition of the Hospital Construction Act. It is apparent then that the emphasis on benefits for medical care and preventive medicine is placed upon the needs of those living far from cities, medical centers, and hospitals. No one will deny that without good health for its people a nation cannot have economical or political independence and no nation can expect to survive either in peace or in war. The local Public Health Services Act of 1948 provides for (1) prevention of illness and injury, (2) prolongation of life and prevention of untimely death, (3) the improvement of individual health. The bill does not provide for medical care. The United States Public Health Service is required to define basic Public Health Services. These minimum Public Health Services may be defined as such services as State and Local Health Departments now or in the future may perform which are deemed appropriate and for which adequate funds are not already provided through other federal grants-in-aid.

Although the bill does not provide for medical care, the United States Public Health Services is permitted to define basic Public Health Services. There may be a loop hole here. Doctor Miller appearing before the Congressional Committee considering the act and speaking as a member of the Board of Trustees of the American Medical Association raised a question in this regard. He said "It is our viewpoint that the law itself should state what shall constitute basic Public Health Services and as a corollary that such determination should not be left to any Federal Administrative Officer". He suggested that the bill be amended adding a definition of basic Public Health Services to include the functions already listed as basic, namely:

1. *Vital Statistics,* or the recording, tabulation interpretation, and publication of the essential facts of births, deaths, and reportable diseases.
2. *Control of Communicable Diseases,* including tuberculosis, the venereal diseases, malaria, and hookworm diseases.
3. *Environmental sanitation,* including supervision of milk and milk products, food processing and public eating places, and maintenance of sanitary conditions of employment.
4. *Public Health Laboratory Services.*
5. *Hygiene of Maternity, Infancy and Childhood,* including supervision of the health of the school child.
6. *Health Education of the General Public* so far as not covered by the functions of departments of education.

and to exclude the care of the sick as a function except where that care is necessary for the protection of the health of the community. The act does provide that all of the funds appropriated be made available to the local units of government without any of the funds sticking to the fingers of either the Federal or State Agencies. When these acts for Health Programs are presented to Congress and hearings held there is a great overemphasis laid on the particular needs that the act proposes to take care of. Last year the Commission to Re-examine the Field of Governmental Operations in Rhode Island, the Cost of Governmental Services and the Tax Structure of the State of Rhode Island engaged outside experts to survey the Departments of Health anl Social Welfare. One of the recommendations was a consolidation of all local health services under the direction of the Director of Health which would increase the staff of the department by 184 and an additional cost of one-half million dollars. The formula was applied in the Rhode Island Survey that was applied nationally and that formula is the basis for the local Public Health Services Act of 1948.

continued on next page

Now the introduction of the local Public Health Services Act of 1948 is a natural evolutionary process in the formulation of plans and programs for continued improvement of the health of the people of this nation. Although the Federal Government is recognizing its share of the responsibility at the same time it is recognizing the rights of states to administer these programs within their own jurisdiction. During the years as a practicing physician and a member of the State Medical Society I have always feared lest these programs might be the entering wedge for federalized control of medicine. At this time I can assure you that although the various Federal Agencies request plans and accounting of procedures, reports, and an auditing of our books, and I think they are justified in so doing, I have never noticed any attempt by the Agencies to interfere with the administration of the Health Department. Present funds are made available for non-controversial preventive and other public health procedures which are already an accepted responsibility and function of local governments. Extension and expansion of basic health services can be made available to all the people without interfering with organized medical practice. Only one question might arise and that is the vast expenditure of money and resultant increase in taxes. However, it is well for us to take care of the needs of our people when so much money is being appropriated to take care of people suffering in foreign lands.

Once again I would like to call to your attention the great interest of lay groups in promoting these programs. A conference on Local Health Units was held at Princeton recently under the auspices of the National Health Council the executive director of which is a layman. The National Advisory Committee of Local Health Units has twenty-eight members representing twenty-eight National Associations. Of these twenty-eight representatives eight are doctors of medicine, one a doctor of dental surgery and one a registered nurse. It is evident that our national health programs are planned and inaugurated by laymen. These lay representatives that serve on national health committees are individuals interested in national health, and I believe are sincere in their thinking but it is easy to understand how such programs as compulsory health insurance receive their impetus and due regard not given to the interests of the medical profession nor the doctor-patient relationship. To give you an insight on how these health programs are promoted, and I do not mean to make an inference that they are not essential nor justifiable. At the hearings on "Local Public Health Services Act of 1948" already such organizations as the National Tuberculosis Association, the American Social Hygiene Association, the National Congress of Parents and Teachers which sponsored the bill have given testimony before the house committee. Now, this is a good bill and has received the endorsement by James R. Miller, M.D. a member of the Board of Trustees of the American Medical Association and also by the President of the State and Territorial Health Officers Association but I am just citing it as an example of how health programs originate and the pressure put on for their enactment. If this bill passes it would make available personnel for the performance of basic Public Health activities at an annual cost of 208 million dollars. The Federal contribution would be approximately one-third of this.

Since grants-in-aid were made by the Congress for the past thirteen years to state health departments for the expansion of health activities there has been the tendency by the Congress to hesitate on appropriating money unless for specific purposes. Whereas a few years ago each State received a grant from the Federal Government for General Health services to be used at the discretion of the State Health Department provided it was not used to replace funds appropriated by the State; each year there is a definite trend to earmark portions of the grant for specific purposes. To members of Congress general health or basic health activities mean nothing. But when a specific appropriation is requested for Cancer, Tuberculosis, Dental Care, Venereal Disease or Industrial Hygiene, the appropriation bill is more certain of passage. Now to overcome this general terminology of general health or basic health needs the present bill for local Public Health Services has been introduced. The question arises how far should a state administration go in endorsing these programs by urging their members in the Congress to support these bills. The passage of this act would be most helpful in granting financial aid to cities and towns for health purposes. Of course if the act passes, Rhode Island will very willingly accept its share. Certainly every attempt should be made to have returned to Rhode Island as much Federal money as is available. At the present time Rhode Island being one of the wealthiest states receives a small proportion in return for the money sent out of the state for Federal taxes. When these Federal Health Programs first originated in 1936, Maine and Vermont refused to participate but soon they realized that although they were not in sympathy with increasing government expenditures, they might just as well get some of the money back from Washington and finally requested their allotment. The formula used with most of these programs is based on the wealth of the State, the need, the population to some extent, and the amount of money already expended by the respective state for health

services. The wealthy state which appropriates well for health services is penalized under this formula and the money that the wealthy state turns in as Federal Revenue goes to the aid of poorer states. When this point was discussed a few years ago the surgeon general told me that we were our brother's keeper.

Last November four National Welfare and Medical Groups recommended a program for aiding the 25,000,000 Americans who are reported to have chronic diseases. Sponsors of the prôgram are the American Public Welfare Association, the American Medical Association, the American Hospital Association and the American Public Health Association. The organizations said that of those with chronic diseases some 7,000,000 are partly or completely incapacitated, and each year nearly 1,000,000 die from such illnesses.

A bill is now before Congress to provide for research and control relating to the disease of the heart and circulation by the establishment of a National Heart Institute. This has received the endorsement of the American Medical Association. As Public Health work has progressed and since life expectancy has been extended because of the great decrease in communicable disease and other diseases of childhood and with the advent of the sulfa drugs, penicillin and streptomycin, great consideration is now being given to the diseases of middle life. In a broad conception of Public Health Work these diseases such as Cancer, Diabetes, and Heart conditions are being considered as possible functions for health departments to investigate.

Under the Federal Hospital Construction Act, Rhode Island will receive $280,000 annually for five years to be matched by non-profit hospitals on a one to two basis. For survey and planning $15,000.00 is granted annually on the same basis. That is $1.00 of Federal money for every $2.00 of State, local or non-profit hospital money. There was a hospital facility section in the recent National Health Assembly. The Federal Security Administrator in announcing the formation of this section referred to the poor distribution of the existing hospitals in the country as a whole and particularly to the scarcity of hospital facilities in rural areas. He suggested the desirability of an analysis of the roles of the various types of hospitals to determine their interrelationships. The section also considered the nations need for health centers and diagnostic facilities. In speaking of hospitals I would like to mention a thought that has been on my mind for the past few months. With the financial status of the hospitals not strong because of decrease in endowment income, increased costs in food, maintenance and salaries, the resultant increase in hospital rates may be used as an argument for the federalization of hospitals and medical care. Rhode Island Hospital has requested and received from the state an appropriation of more than a quarter million dollars to cover deficit for recently closed fiscal year. You may have read recently in the press that a deficit of $900,000 threatens the existence of the great medical center of the world famed Johns Hopkins Hospital. At the hearing before the House Finance Committee when the request from Rhode Island Hospital was being considered the question was asked "will this not head to government control?". With the high cost of living and the high cost of hospitalization the people are feeling the pinch and it behooves the members of the medical profession to consider well the financial condition of the patient before charging a fee particularly for a surgical operation that is out of proportion to the patient's ability to pay. Senator Murray who is deeply interested in the Murray-Wagner-Dingell Bill has recently said "Unless the Congress enacts a health insurance measure the proposed tax rebates so sorely needed by each family to pay for food, clothing and shelter can be eaten up by a single surgical operation".

The Hospital Construction Program is now being considered under authorization of the Federal Act and by an act of the Rhode Island Legislature last year. The State Department of Health has been designated as the State Agency for carrying out the Federal program. In brief, it provides for survey of hospital facilities and public health center needs; also for planning later financial aid to non-profit hospitals in any construction they may undertake. To qualify under the Federal Program a State Agency must have an advisory Hospital Council and this Council appointed by Governor Pastore has been working diligently for several weeks. It is apparent to all that there is a shortage of general hospital beds in the State. The survey which has been under way has been completed and the plan is ready to be presented at a public hearing required by law.

How much the new Veterans Hospital will lessen the demands on our hospitals here in Rhode Island, time will tell. Several hospitals are planning additional maternity wings. Whether or not these will be needed in the future remains to be seen. I feel that we have reached the peak in the great increase in births. There again, time only will tell. For the coming five year period one and one-half million dollars will be allocated to Rhode Island upon the due approval of applications from hospitals desiring assistance. For every dollar given by the Federal Government, $2.00 must be provided by the non-profit hospitals. With the estimated cost of $20,000 per bed in the hospital construction it is apparent that the grant to this State is not large. Again since nearly all Federal grants are allocated on a formula basis and since Rhode Island is one

continued on page 570

ACUTE ASCENDING PARALYSIS*

Case Report of Repeated Attacks With Complete Recovery

WALTER C. WEIGNER, M.D.

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ACUTE ASCENDING PARALYSIS terminates fatally in the vast majority of cases. Death is practically always due to respiratory failure and often in spite of the use of a respirator. Complete recovery of a severe case with respiratory paralysis necessitating the use of a respirator is therefor by itself worthy of report. When in addition the patient's past history indicates that this is the second episode of acute ascending paralysis with complete recovery, the case report is doubly significant. Review of the literature does not reveal any similar case report of repeated attacks with complete recovery.

CASE REPORT

A white housewife age 60, on April 18, 1944 developed a sore throat, felt "grippy" and had some loose watery stools. Within twenty-four hours she developed slight headache and complained of numbness of both feet. On the following day the numbness extended upwards to include first both legs and then both thighs. Weakness of both lower extremities developed concomitant with the ascending parathesias. On the third day similar numbness and weakness developed in both hands spreading quickly to involve all of both upper extremities. By this time both lower extremities were completely and flaccidly paralyzed and weakness of the trunk muscles was developing. On the fourth day, patient had difficulty in swallowing and she could not lift her head from the pillow. All four extremities were now completely paralyzed. She complained of a choking sensation and could not swallow. Her color was extremely pale and her general condition appeared alarmingly poor. Up to this time she had complained of no pain except for slight headache and backache. There had been no chills or fever.

Upon hospitalization, examination revealed a pale and exhausted appearing woman lying motionless except for shallow breathing. She was mentally clear and answered questions in a feeble voice. Her most distressing complaint was difficulty in breathing and observation revealed that breathing was entirely abdominal there being no evident use of the thoracic muscles.

Examination of the cranial nerves revealed the pupils to be of medium size reacting promptly to light. There was no ptosis of the eyelids or strabismus. Diplopia was denied. Eyeball movements were full and equal in all planes. There were no sensory disturbances over the face. No facial weakness was present. Hearing was within normal limits. The gag reflex was present and the tongue protruded well and in mid-line.

The tendon reflexes were absent in all extremities. All extremities were completely and flaccidly paralyzed. Compression of the muscles of all extremities elicited moderate tenderness. Feeble rotation of the head supported on the pillow was possible but patient could not raise her head from the pillow. She could not elevate her shoulders nor was she able to use her trunk muscles.

Sensory examination employing light touch and pin prick over the entire body surface revealed normal sensibility. Position and vibration sensations were intact. Sphincter control was not impaired.

General examination revealed the temperature to be 98.6, pulse rate was 116, and blood pressure was 180/100. There was slight injection of the pharynx. Heart action was regular in rate and rhythm. No murmurs were heard. Lungs were resonant throughout. Abdominal examination revealed the muscles to be extremely relaxed. No masses were felt and there was no tenderness. Examination of the extremities revealed no edema and there were no evidences of nutritional or vasomotor disturbances.

Laboratory studies revealed the urine to be normal except for the slightest possible trace of albumin. Blood urea nitrogen was 12 milligrams per 100 cc. Red blood cell count was 4,650,000, white blood cell count was 11,250 with 77% neutrophils, 19% lymphocytes, and 4% monocytes. Blood

* Presented before the Providence Medical Association, at Providence, April 5, 1948.

hemoglobin was 15.7 grams. Spinal puncture revealed the spinal fluid pressure to be within normal limits. Clear colorless fluid was obtained. Cell count was 2 lymphocytes per cubic millimeter. Total protein was 50 miligrams, glucose was 88 milligrams, and sodium chloride was 735 milligrams.

During the fifth day of illness, respiratory difficulty increased, slight cyanosis developed and patient lapsed into a semi-comatose state. At this point she was placed into a respirator where her color quickly improved and she roused sufficiently to converse feebly. She could swallow nothing however and fluids were given by proctoclysis.

On the sixth day, patient appeared stronger and she was able to wiggle her toes and fingers slightly. On the seventh day she was able to move her left hand and forearm slightly and on the eighth day she was able to move both upper extremities slightly. On this day she felt much better generally and was able to be out of the respirator for several fifteen minute periods. Her breathing however was shallow and she complained of breathlessness.

By the tenth day there had been further return of power in the upper extremities to such a degree that patient could move them fairly well. The lower extremities however continued to be completely paralyzed.

By the twelfth day there was such a marked improvement that further use of the respirator was no longer indicated. Breathing was now adequate and easy, color was good, and patient felt much stronger and more comfortable generally. From this point on recovery was steady but gradual. Power slowly returned to all the previously paralyzed muscles and by the twenty-fourth day fair strength had returned to all extremities. By the thirty-sixth day patient was able to be up and about for short periods and on the forty-fourth day she was discharged to her home.

At no time throughout this illness did patient run any elevated temperature. At no time was there any loss of sphincter control. No special medicinal therapy was employed.

Patient was next seen approximately five weeks later at which time she reported that she had been up and about leading a normal but quiet life at home performing light household tasks. Good power had returned to all extremities. Neurological examination at this point revealed all tendon reflexes to be present and lively. The only symptom that patient reported at this point consisted of occasional pins and needles parasthesias in both feet. Objective sensory examination however was normal. No tenderness was present on compression of the muscles and all extremities possessed good power. No muscle wasting was evident.

Three months later patient was again seen at which time the tendon reflexes were still lively. No muscle tenderness or muscle wasting were present. She reported that the parathesias were still present but that now they were limited to the dorsum of the left foot.

In June 1946 (thirteen months after onset of illness) patient was again seen. The tendon reflexes were now of normal intensity, the parathesias had entirely disappeared, and patient had no complaints. Muscle strength was excellent and patient looked very well.

Additional History

At the time patient was first hospitalized, she stated that many years previously she had had a similar illness consisting of numbness and paralysis of both lower extremities from which she recovered completely in several weeks time. Her husband and sister verified this statement but could not supply any definite details. Unfortunately the physician who saw her at that time had long since passed away and no records were available. When the patient recovered from her acute illness, the history of this previous attack was gone into more carefully and the following information obtained.

The illness occurred when she was thirty years of age and at a time when she was very tired from a busy schedule. She had had a "cold" but had recovered from it and was up and about although she felt extremely exhausted. A few days later she developed numbness in the soles of both feet and during the course of the subsequent week this numbness extended into the toes and then throughout both feet. During this period she felt vaguely ill but does not recall any sore throat, fever, or gastrointestinal disturbances. The numbness then spread rapidly first ascending to the level of both knees and then climbing up both thighs and into the lower back. Within forty-eight hours she was unable to move either lower extremities and her back was so weak that she was helpless from the waist down. Her arms were never affected nor was there ever any loss of sphincter control. She recalls no temperature or headache. At no time did she have any difficulty with her breathing or swallowing.

This previous paralysis from the waist down lasted about two weeks and during the following week all numbness and paralysis disappeared. Except for generalized weakness she felt well. Subsequently she had no difficulty whatsover with her lower extremities and lived an active and normal married life bearing two children without any difficulty.

DISCUSSION

Medicine is indebted to Landry who in his monograph upon the subject[1] focussed attention upon the phenomenon of ascending paralysis in 1859.

continued on next page

He described an acute and highly fatal form for which he established the following criteria.

I. Symptoms of rapidly ascending motor paralysis.
II. Absence of significant sensory phenomena.
III. Freedom from sphincter disturbances.
IV. Absence of pathologic changes in the nervous system.

Since Landry's time a number of cases exhibiting the phenomenon of ascending paralysis have been reported. These case reports however have to a large measure indicated that our knowledge of the whole subject of ascending paralysis is far from complete. Some writers feel that a morbid entity such as described by Landry does exist and that the term Landry's paralysis is justified in referring to a certain type of ascending paralysis. Other writers however noting the frequency with which cases of ascending paralysis do not fulfill the criteria laid down by Landry feel that we are dealing merely with a disease syndrome behind which there are various and multiple etiological factors and presenting various pathologic pictures. The literature on the subject is consequently in such a state of confusion that one recent writer has suggested that the whole chapter on ascending paralysis should be rewritten. Certainly there is need for a number of new case reports based upon careful observation and employing the latest techniques of diagnosis and neuro-pathological study.

If one reviews the reported cases the majority of which are labelled in the literature under the common heading of acute ascending paralysis one is struck by several glaring facts. One is that the clinical and pathological pictures vary so greatly that all writers cannot possibly be referring to the same disease process. For example, many writers report cases which follow the classical description as portrayed by Landry and fulfill the previously enumerated criteria. Their cases present an acute onset, pursue a rapid and highly fatal course, and present little or nothing at autopsy. Conversely others report cases in which the onset is gradual and the progress slow, objective sensory losses and sphincter disturbances are present, and a wide variety of significant changes in the peripheral nerves, spinal cord, and even of the brain are found on autopsy. It is difficult to reconcile such divergence of clinical and pathologic facts. It seems unreasonable to view as identical illnesses one case that fulfills the criteria of Landry and another case for example where the ascending paralysis is associated with leukemia and shows leukemic infiltration of the cord on autopsy.

The second fact that a review of the literature reveals is that the diagnosis and treatment of a case of ascending paralysis represents a problem involving not only the neurologist but the internist as well. Every case poses a problem of etiological determination extending beyond the realm of neurology. The mere diagnosis from the neurological point of view without careful study directed toward a determination of the many possible causal factors is of little meaning. To consider all cases of ascending paarlysis as Landry's paralysis is not only absurdly unscientific but is potentially dangerous. To appreciate these points more fully let us turn to a brief review of the literature as it relates to the reported etiologies and pathological pictures.

Ascending paralysis has been ascribed to such a variety of causes that no single etiologic factor can be said to operate in all cases. It has been reported in sheep,[2] in dogs,[3] and in humans[4] as a result of tick bites. In these cases the paralysis is ascending, symmetric, and flacid. Reflexes are lost and there is no fever. On removal of the tick, the symptoms gradually disappear in the reverse order of their development. It is not known whether it is the saliva itself of the tick or some infective agent in the tick that is responsible for the paralysis. Acute ascending paralysis has also been reported[5] as being caused by the sting of the weaver fish. It has followed closely upon the administration of cold and other vaccines[6] and also following anti-tetanus inoculation.[7] A case has been reported in metabolic disease with hematoporphrinuria.[8] Pregnancy has been indicted as a factor[9] and it has been reported as coming on during or following infections including typhoid fever[10] and malaria. It has been reported in association with herpes zoster,[11] lymphogranuloma without lymphogranulomatous infiltration of the cord[12] and in leukemia with leukemic infiltration of the cord. Rabies[13] and anti-rabies vaccine[14] have also been indicted as causes of acute ascending paralysis. There are several other perhaps more common causes. For example, ascending paralysis can be an unfortunate complication following spinal anaesthesia and due to an ascending myelitis presumably on a toxic or anaphylactic basis. It can be due to syphilitic disease of the spinal cord or it can result from pyogenic infection producing an epidural abscess. It can also be due to metastatic disease of the vertebral column or of the spinal cord itself. An ascending character to the paralysis is often seen in acute infectious polyneuritis and in some cases due to peripheral neuritis due to toxins, alcohol, vitamin deficiency, etc. Just recently there has appeared a report of fish poisoning occurring at Fanning Island in the Central Pacific.[15] Cats, dogs, and domestic ducks eating these poisoned fish develop ascending paralysis in a few hours while humans develop numbness and tingling over the entire body with great muscular weakness. The very interesting fact is that the ten species of fish now poisonous were eaten without

continued on page 572

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SOCIAL INSECURITY

THE NEWS HEADLINES on July 4 reported that the residents of England and Wales would henceforth "stop worrying about doctor bills" as the national health service was being started. A bright picture was painted of the happy lot of the British population as having the best of everything in medical and allied health care—for free, or for "small sums" deducted from weekly salaries. Again the Socialist State was pictured as utopian, and the American public was exposed to the subtle propaganda of ideal existence in the welfare state of Great Britain.

Few Americans are fully conscious of the fact that they are heavy contributors to the financial structure which makes the Socialism of Britain apparently workable. Consider what a difficult position Britain would be in without Marshall Aid. As the British Information Services has reported,

> ". . . To mention only a few effects, Britain's rations of butter, sugar, cheese and bacon would have had to be cut one-third; there would have been less meat and eggs; tobacco would have had to be cut by three-quarters; there would have been less footwear and cotton goods; house building would have been reduced by 50,000 homes a year; and, with the general shortages of raw materials, unemployment might have increased to one and a half million and more."

Yet this is the country that initiates its overall new social insurance and social security services which the American press exploits as costing but "a small sum" from each worker. A small sum indeed. But what of the increases in Government expenditure estimated for 1948-49 by Great Britain which will amount to $780,000,000, of which education will take $120,000,000, housing $56,000,000, and the *National Health Service $572,000,000?* No mention of these staggering outlays, in addition to the other taxation, is made when picturing the "cradle to grave" security that is to be so grand at supposedly low cost.

As has been shown clearly in studies in all lands, the health of a nation depends as much, if not more, on nutrition, housing, sanitation, recreation, and many other vital factors as it does on medical and hospital services. But consider the food position alone of Britain as the Government expands its social services this summer.

Before the war the daily food intake for a Briton averaged 3,000 calories. In 1947 it fell to 2,880, and it was scheduled to be cut still further to 2,681 per head in the first half of 1948. Translated into nutritional terms, there is a fall below pre-war protein intake in 1948, and a severe fall in fat intake. Meanwhile in the United States the average per

continued on next page

capita daily food intake is close to 3,400 calories.

Even with the Marshall Aid there is no suggestion that the British position will be eased for the remainder of this year, and the hope of every Briton as he tightens his belt is that the situation will not become any worse.

Yet this is the country that paternally expands a "security" program in an effort to cover up other shortcomings in the economic pattern, and all the whiles enslaves further thereby the entire population.

Only the European Recovery Program, supported by American money, will avert rising unemployment in Britain. Although the local employment exchanges of the ministry of labour and national service operate under a procedure that is basically by voluntary consent, yet the Government has certain directive powers which allow it to compel all workers seeking employment, and all employers seeking workers, to do so through the government exchanges. The Government has only once used its further authority to require persons who are not gainfully employed or who are in non-essential work (as determined by the Government) to register at the employment exchanges where they are offered a choice of jobs "more in the national interest." Nevertheless it has that whip available for use at its pleasure.

Is this the kind of security of free choice of work that the labor organizations of America would welcome as they hail the expansion of European social security programs as models for America to adopt?

Originally social insurance was intended for the very poor. It was considered as an aid during periods of economic distress, not complete aid, but partial assistance to ease the burden. But that concept has been altered. Today the talk is overall security to meet all costs, thus destroying the personal initiative, leaving in its place a dependence on the State to protect against the economic and social uncertainties of modern civilization. By the simple expedient of paying a fifth or a quarter of our annual earnings into the Federal government we are led to believe that we will have security against the hazards of life—though cash sickness benefits, unemployment payments, free medical and hospital care, old age pensions, and maintenance of our dependents when we die. As we are lulled into dreams of an utopian future, even as the Britons, federal and state legislation is constantly being prepared to hold us fast under government controls even when we finally awaken from our slumbers.

In this, an election year, we hear great promises —pledges to increase the social security benefits on the national level. We should recognize clearly in such promises that politicians have been quick to seize upon, for tax purposes as well as for votes to gain office, these ideas for the promotion of the Welfare State.

When will we awaken to the importance of making a complete study of our existing social security program? Of what real value is it? Where has the money gone that has been paid into the fund? How will even the present benefits be paid to the potential claimants ten or fifteen years from now?

The American Bar Association initiated action recently with a resolution which reveals that 99.5 per cent of the funds thus far accumulated under the Social Security Act have been spent on public projects, and that special non-negotiable Government obligations have been substituted for "86.26 thereof." The resolution also reports that "such part of such sum as may be necessary to meet extraordinary demands which may arise in the future will of necessity have to be raised by the sale of negotiable bonds or by the imposition of taxes to redeem the non-negotiable obligations."

Briefly, then, the money paid into the system has been spent. When money is needed to meet the demands, the same people who have been paying will have to pay their share to reactivate the fund —in other words a double taxation.

What kind of security is that for today's worker?

The propoganda for socialism strikes a ready response from many of our people who are innocent idealists motivated by an intense humanitarian urge to give everybody a fair chance. They are honest people for the most part who become impatient with the attainments of our American system and think that by the compulsion of Government we may speed up the attainment of goodness. These people are willing workers for politicians whose motives are only for a bigger central Government in which they will be the masters.

Therefore, as we read and hear of the European socialistic experiments in extending social insurance, and as we are bombarded by the political addresses and promises in our own country in the coming months we should be alert to the full implications involved.

Mr. Clement Attlee has stressed what he calls the democratic character of the British program by stating that:

> "We have rejected all short cuts and suggestions that by laying aside our democratic principles for the time we can more rapidly achieve Socialism; the methods by which the end is sought profoundly affect the nature of the end attained. A society changed by undemocratic methods loses the habit of democracy; a society that casts aside in the struggle all moral principles loses those principles. Socialism is a way of life, not just an economic theory, and in the process of achieving socialism we have all got to grow into being fit citizens of the state."

We in America are greatly concerned over the

threat of Communism, but we should not accept the mistaken idea that socialism is a foe of communism. On the contrary, the economic ideals of both are identical, for both believe in government ownership and operation of the means of production. As Henry Hazlitt has so well stated, "Once this ownership and operation become sufficiently extensive, the government has economic life-and-death powers over the individual. It can say where he must take his job, what job he must take, or whether he can take a job at all. And once the government has this power, the liberty of the individual has in fact, if not in form, disappeared. As Alexander Hamilton pointed out in the Federalist Papers a century and a half ago, 'A power over a man's subsistence amounts to a power over his will'."

Both the major political parties in the United States have for vote getting purposes advocated in their national platforms the development of social insurance programs through taxation. But one by one the States are asking for a redefinition of the functions of the Federal Government and for the restriction of its activities. The States are beginning to realize that the wealth that is taxed by the Federal Government is within the boundaries of the 48 states and could be taxed directly by them and the revenue spent by them and large sums saved thereby. No better illustration of this can be set forth than the fact that the recent income tax reduction equals in nearly every one of the states the cost of their schools and libraries.

As doctors we are rightfully concerned about any proposal in any form for the nationalization of medical services. As citizens we are more deeply concerned that the great numbers of our population may become misguided idealists who will be used by politicians who would extend their powers through a centralized authority at the national level. We would caution all to be mindful of the statement of Daniel Webster in the early days of our Republic:

> "There are men in all ages who mean to exercise power usefully, but who mean to exercise it. They mean to govern well, but they mean to govern. They promise to be kind masters, but they mean to be masters."

The vast majority of the medical profession have no desire to live or to practice in a servile state.

WAR MEMORIALS

During World War I the Rhode Island Medical Society lost one of its members while he was in the service of the country, for Lieutenant William H. Buffum, MC, USNR, died in Liverpool, England, in 1918 while on service with the Rhode Island Unit. His memory has been fittingly perpetuated by his fellow medical officers of Navy Base No. 4, the Rhode Island Hospital Unit, by the erection of a bronze tablet in the Medical Library.

In World War II the Society lost by death four of its Fellows who had answered the call to service with the armed forces. By action of the Council the Board of Trustees has been authorized to prepare and have erected a memorial tablet in the Library to the memory of these physicians.

The tablet has been completed and now occupies a prominent position in the main corridor of the Library that we may always be mindful of the supreme contribution made for the safety and peace of these United States by Drs. Arthur Martin, Raymond Luft, Irving Blazar, and Milton Korb.

As we view these war memorials may we offer the prayer that they shall be the last we shall ever have reason to erect, and may we hope that the peace for which these physicians have given their lives may extend far, far into the future.

STATE CANCER CONFERENCE

Reserve the date of Wednesday, November 17, 1948 for a meeting at the Rhode Island Medical Society library.

That is the urgent request to every physician in Rhode Island from the Cancer Committee of the Society, and it is given this early notice so that conflicts in meetings and appointments may be avoided.

Conscious of the importance of medical education in the diagnosis and control of cancer, the newly organized committee of the Society, under the direction of Dr. George Waterman, has decided upon an all-day meeting on November 17 at which outstanding local and national authorities will be invited to present scientific papers on the latest developments in cancer research and treatment.

The plan certainly warrants the support of the membership of the Society. The tremendous amount of publicity that is annually directed to the public relative to cancer places an additional requirement upon every physician that he be versed in the latest medical techniques and studies in cancer diagnosis. The program planned for November 17 will provide a home-town postgraduate course that no doctor should miss.

In addition to its state conference, the cancer committee is considering the distribution monthly of printed clinical material on cancer that will form the basis for a valuable reference text for every member of the Society.

THE JOHN F. KENNEY
ANNUAL CLINIC DAY
Wednesday, November 10
at
THE MEMORIAL HOSPITAL

THE DOCTOR'S ROLE IN COMMUNITY PROGRAMS*

HUGH R. LEAVELL, M.D.

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I SHOULD LIKE to discuss the problem of the "Doctor's Role in Community Programs" from three points of view.

First, the doctor must know what constitutes an adequate community health and welfare program. He must be able to make a diagnosis, just as he would in the case of a patient.

Secondly, he must assume more responsibility than the average citizen would be expected to assume for community health and welfare activity.

Then the third point is that the doctor's wife should carry her portion of responsibility for community health and welfare.

It seems to me important for us to recognize that we, as doctors are, as the newspaper people have told us, an independent group. Many of us have gone into medicine because we thought it would be at least one of the few independent sort of jobs that were left. We have habits of authority which are quite natural to us in connection with dealing with our patients.

However, when we come to surveying the community, we must acknowledge we are laymen in the matter of community organization. We have a voice in community organization. We are part of the community. But, unless we make ourselves experts in the field, we are no more entitled to speak authoritatively about community propositions than most any one else.

To acquaint ourselves with the community's needs, obviously one of the first things we must do is to make an examination or survey, and try to find out what the needs and the resources are.

What are the agencies involved?

What are the methods used in referring patients, or clients, as the social workers call them, from one agency to another?

How do these things operate?

There are people who make a special business of surveying various agencies and communities. There are agencies, such as certain branches of the American Medical Association, the American Public Health Association and so forth, which may be called in to provide expert help in diagnosing the community.

I think we need to have certain standards for what we will consider an adequate agency.

What are some of the characteristics of an agency which we might reasonably expect would be qualified to serve the community in the proper sort of way?

Today we should expect trained personnel and people working at their jobs full-time. I have had personally the experience of being a part-time health officer, and I know that it doesn't work. There was never a time when there was an important budget or committee meeting associated with the Health Department's work, that my favorite patient didn't turn up with an acute emergency, so right then and there, it was necessary to decide whether it was going to be the patient who would get first consideration or the Health Department.

In this modern day, I believe we cannot expect adequate service from people working in these agencies on a part-time basis.

There must be adequate finances to operate, if we are to have trained personnel, and expect them to give their whole time to the activities, because we must be able to pay adequate salaries.

It is estimated that to do a reasonable public health job, (one segment of the community program) it will take $2.00 per capita. To provide hospitalization, we can figure that the average person requires one day of hospital care a year, and whatever a day of hospital care is quoted at on the current market, we will have to provide for the hospital share, and so on, down through the other aspects of the work.

I think we must say that to have adequate community agencies, they must be given freedom from

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political interference. We can't afford to run programs of this sort with the necessity of a turn-over and entirely new personnel when there is a change in local administration. We must have, therefore, a merit system which provides security for the community rather than life tenure for the employee, which, of course, was the original objective of civil service. Somehow that has gotten to the point where it is presumed to provide life tenure for the individual rather than a life protection for the community.

Agencies in our local communities must be responsible to local desires. If you look at the National Health Program of the American Medical Association, you will see running through it emphasis on the importance of giving local communities the opportunity to have a voice in services provided by local agencies and through other agencies, state and Federal as well.

If the agency be a governmental one, of course it must have sufficient legal authority to do a proper job. The Health Department is one of the outstanding examples. It must have certain legal authority to enable it to discharge its functions. That authority may almost never have to be used, but it should be available.

Those, then, would be some of the criteria for adequate agencies.

Just to take an example in the field of public health, how are we going to get trained personnel doing full-time jobs, with adequate finances to run a balanced health program, requiring public health nurses, sanitary engineers and people of that sort, in many of our small New England towns? I think this is a problem with which we must deal very, very carefully and rather promptly, if we are going to have a proper public health set-up in New England, because a town of 700 or 2,000 people simply can't afford to have a full-time medically trained public health officer and the other things that would be necessary to make an adequate staff. There must be some method found for uniting these towns for health purposes just as it is necessary to unite them in the school districts and things of that sort.

Another aspect is the proper arrangement for planning and coordination. As communities grow larger, the number of agencies concerned with health and welfare begin to multiply, and we need some coordinating mechanism.

Now, the best mechanism that has been found, as far as I know, is the community council, with the various committees on health, welfare and other aspects of community activities; the health council, which would be composed of representatives and officials of voluntary agencies and of the general public.

I hope that as we talk about this whole community program, we will remember that the general public needs representation. We mustn't always be thinking just of agencies, such as the medical society, the health department, the hospital, the visiting nurse association, etc., but the general public, the consumer of what we, as medical people, are producing. They should have some voice in the things we are turning out for them. In health councils, and activities of that sort, they may have opportunities to express themselves. These health councils should be not mechanisms for coercion, but places where people can get together and talk over their problems, and reach a common decision. They should be sufficiently representative of the community so that when a decision comes for example, that the health department should take such-and-such an action, the health department wouldn't feel necessarily bound to do that, but it would feel that if the action were not taken, the community would want to know why.

I think it is important for us to remember that health councils of this sort, representative of the community as a whole, must not be thought of as a tool that may be used for some particular purposes.

I can give you two examples. The National Health Council has been interested in promoting the formation of local health councils. At the moment, one of the reasons given for this is so local health units may be developed, with people serving as full-time health personnel.

Now, that is a perfectly good objective, but it ought not to be the primary reason for forming the health councils.

Again the American Medical Association has suggested that local health councils be formed to promote voluntary health insurance. It may be they would be useful in that. But, in itself, that is not the proper objective of local health councils, either.

The purpose of a local health council is the community's needs and problems, and help to find solutions for them, wherever they may be. It should not be used as a tool for the National Health Council, the American Medical Association, the A. P. H. A. or any particular group other than the community it represents.

Another thing that we need to know and provide for in our community program is that of evaluation. We pay a certain degree of lip service to periodic examinations for our patients. Our communities should actually have a periodic evaluation. In the health field, that is about as scientifically possible as in any field of community activity at the present time.

What about the doctor himself?

How can he implement these ideas through the medical society and individually?

Well, I think you have a superb example in this

continued on next page

meeting. For, we are having a scientific meeting on community problems. We are not talking about subluxation or the sacro-iliac synchondrosis, but we are trying, scientifically, to approach this problem of the community and public relations.

Why can't we have scientific programs about community health and welfare problems, and by that I mean programs where we attack the questions, not with preconceived ideas, but with open minds, just as we would expect our audience to have if we were going to present a medical, scientific paper on some technical subject.

We need to have in our medical society committees studying health and welfare problems; committees on public health and medical care and medical education.

I think that anyone familiar with medical education today will recognize that relatively few medical schools are giving students proper instruction in how people live together in a community, and how they find ways to meet their medical and health needs from the community's standpoint, the "social" aspect of medicine. Somebody usually sticks "ized" on that and makes it an entirely different thing. But by that I mean study of community health problems and how they may be solved, just as an individual has his health problems and how he has them solved.

We are especially happy in Massachussetts to have John Conlin, whom we were fortunate enough to have as a student at the Harvard School of Public Health during the past year. He made some real contributions to us there, and we feel that he can help to understand some of the problems that public health people have and that the community has, because he has gone at it from the standpoint of trying to learn about these things. More of that needs to be done in medical schools than is being done at present. We need more interest in legislation. We can whip up a tremendous show, as has been demonstrated with reference to the Nolen-Miles Pound bill, and it is a great thing that we can do that. But, by-and-large, it is difficult to get members of the medical profession adequately represented in reference to legislation.

What about the doctor as an individual citizen?

Well, he can serve as a member of the board of health, the board of voluntary health agencies and health councils. He can do a job of community education. If he knows about these problems, and is sympathetically concerned towards them, he can do a great deal by talks with his patients. I remember hearing the Dean of the Ohio State Medical School tell about how he got six million dollars from the Legislature for his medical school. He simply had all the graduates of Ohio State talk to the members of the Legislature in each of the various districts. Here were the doctors talking to their patients about community problems, and the State Medical School gots its appropriation.

Radio and newspapers have been discussed very well today. I had one experience with a medical news column, which was run on a daily basis in a local newspaper, the articles being furnished by various members of the medical society. They did have to go through a little editorial process, but the project ran on for about three years, and it was rather useful.

Also, doctors can serve as members of a speakers' bureau, working through our various social and civic clubs.

All these are things that we can do for community education.

Now, as to our professional services: How do we make those available in a community program?

Well, of course, first through providing preventive medical services for our own private patients; there, we are rendering a definite community service. I shall not go into detail about that, except to point out that I think we do need to get some new ideas about the periodic health examination. Let us find out what it is worth, what aspects of it we can apply on a broad scale to our patients, and stop talking about how we ought to do it, but not doing it, as I am sure most of us don't.

We can serve in other ways; as school physicians, working in child health conferences, cancer clinics, clinics for crippled children.

We can do a community job by cooperating with our health department in fulfilling our legal requirements, by promptly reporting communicable diseases, births and deaths.

We can even take a little responsibility which we are not legally required to do, and report unsanitary conditions and welfare needs that we may run across in connection with our trips about the communities.

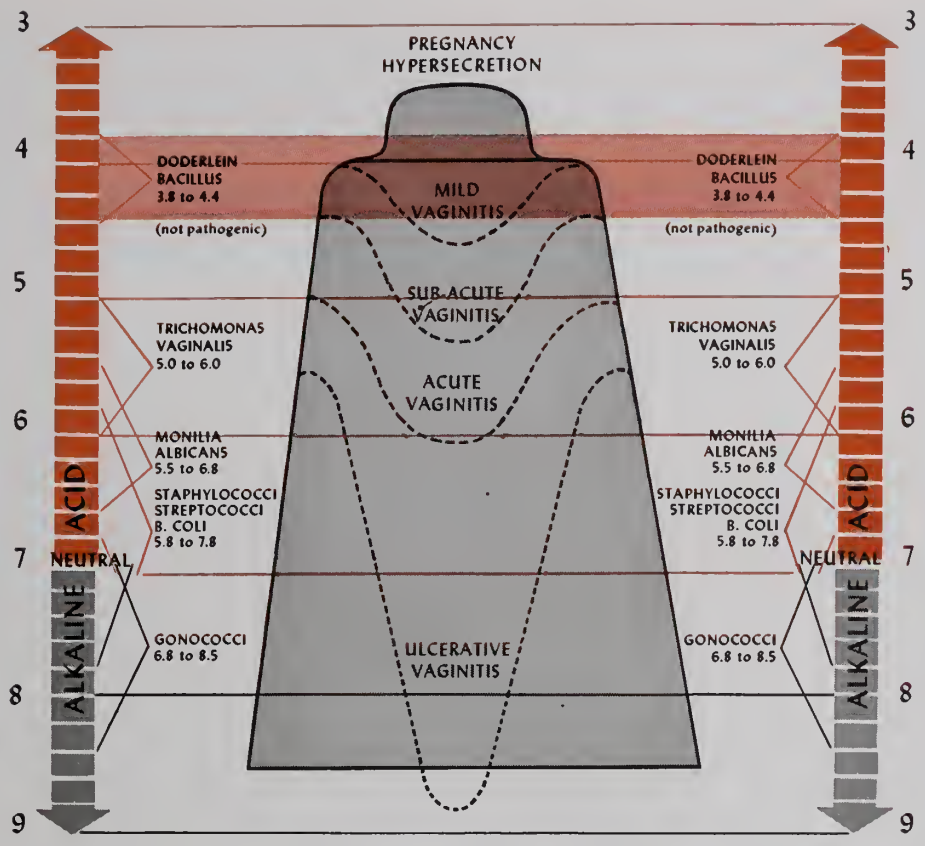
Then, I think that the doctor's wife can do an important job in this community program. She has contacts with patients which, many times, are more crucial than those we have ourselves, and certainly she gets little enough recognition for them, I am afraid.

Now, through the medical society auxiliaries, which I am glad to see are being strengthened, the doctors' wives will have opportunities to make themselves felt more and more; also as members of their particular social and civic clubs, especially the parent-teacher groups. And then I think the doctors' wives have an opportunity to do a rather important community job for us by training our children in the community's responsibilities which they are going to have in the future.

I haven't given you a bit of new medicine here.

I haven't even mentioned anything that you didn't already know.

continued on page 566



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DOCTOR'S ROLE IN COMMUNITY PROGRAMS
continud from page 564

But, I do hope that perhaps I have indicated some lines along which I think it is possible for the doctor to work.

In introducing me today, your Chairman made one mistake. He said that Dr. Leavell has time enough to do a number of these different things. Well, I don't have the time, and I know that you don't either. But, on the other hand, if you are interested in health matters and in the health problems of your community, you will find the time to do those things, and you will find the time to become better acquainted than the grocer or the undertaker with how the community anatomy and physiology operates in the health fields.

And by the way, one of our newspapermen, perhaps both of them, spoke about the problems of understanding between the medical man and the journalists, and one of the problems was the deadline. I just want to say that I think the undertakers could understand deadlines much better than the doctors!

DISCUSSION

ROBERT O. BLOOD, M.D.

Former Governor of the State of New Hampshire

I AM VERY HAPPY to come here and get a chance to talk to doctors. I think the situation now is somewhat similar to the minister who berated his parishioners for not going to church. The ones he should have talked to were not there. And that is true today. The ones we should talk to on this type of subject are not here.

The New England Council of State Medical Societies is doing a grand job, and it should be complimented on considering this subject.

A newspaper man got hold of me this week, and wanted to know if we, in New Hampshire, were doing anything on public relations of the doctor. This paper which you have just heard is an excellent one, and it is one of the types of papers that you cannot disagree with; it is difficult to add to, also. And certainly, I would not want to change it.

The physician is in a rather peculiar position at times, and we have few laymen who are placed in the same dual position.

This reminds me of a youngster five years old who said to his mother, in 1940, when I was first running for Governor and I was going out with his daddy in the evening, that he wanted to stay up until I got there, as he wanted to see me before I went out. I don't know what sort of an individual he thought he would see. When I came, I overheard him say to his mother:

"How can a man be a doctor and a Governor, too?"

I think that sometimes we medical men get an idea that we are quite different from the layman; because we are doctors, we are nothing else. Someone already has said that we must remember we are laymen, also. When the doctor gets that into his system and his mind, he knows that he should be interested in health and welfare matters, our hospitals and hospital programs, etc. Then we are a great deal better off, and public relations will be much better.

The people who get things done in legislatures, community councils and the like are the people who put the greatest amount of pressure on and present their case better, in order to make it appear that they are the majority of the public. And may I say, with possibly a little criticism of the medical profession, that it is not the medical profession that is usually doing that.

I was very much interested in the statements with reference to the press and public life. A man who is in public life has to meet the press, and if he doesn't tell them what they want to know, they will say something that he doesn't want them to say, usually, so you might as well tell them the truth.

As to dead-lines. I have never, in all of my public life, had a newspaper break a deadline. If you don't give them a deadline on the story, then you will find that they will get something that you want to keep as an important announcement, in the future, appearing before you want it to appear, and the story is not the way you wish it to be.

I should like to make an appeal to you as medical men and as missionaries back home to the other medical men of our New England states, to take a position of leadership in this health field, because that is the place that we, as physicians, are best

continued on page 568



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1. Haven Emerson: Journal Lancet, 57:1, 1947. 2. Registered trademark, Sharp & Dohme. 3. M. Clin. North America 27:567, March 1943.

MULSAVITE

DOCTOR'S ROLE IN COMMUNITY PROGRAMS

continued from page 566

qualified to be the leaders; in fact, no one else is qualified to lead, except the medical profession.

Then, too, if we all say: "I haven't the time to do this or that; I haven't time to belong to the Health Council or any other agencies that are doing a health job,"—then the lay people are going to use the health programs and they are going to regulate medicine, and you and I are going to take the laws they make.

One of the best ways to handle legislation and community activities is the relationship that the doctor just spoke of.

If the individual physician talks to the individual politician, whether it is about a music program or any larger program, the politician will be much more influenced than by several letters either by doctors or laymen.

I have been very much interested, also, in looking up things with reference to the question on where we are going in medicine, and what we are going to do, for that is a vital question.

We all know, I believe, that we are never going back to the old times; we are going forward to new times.

So I looked up the first law that established a Board of Health in our State of New Hampshire. The law was passed in 1881, and in that act, it stated that there should never be spent in any year in the State of New Hampshire for Board of Health purposes any more than $3,000.

Last year, in the State of New Hampshire, we spent in State, Federal and Public Health matters, $577,000 plus, under the direction of the Board of Health. We spent in a welfare field closely allied to medicine $6,000,000 plus.

And, speaking of welfare, we in the public health and community relations and community programs, must always remember that welfare is equally important almost with medicine. And, what happens in the welfare field of sanitation, community relations, public health, etc., will make or break the public health situation in that community.

This is a subject which we could spend much time on.

I just want to appeal to you to continue this type of work, Dr. Ruggles. I want to tell you that I think you are doing a great service to the public, and may we, the doctors of today, do what the doctors of the olden days used to do, when education was less generally well distributed, and the two men in the community who were the leaders of the community were the minister and the physician.

If the physicians truly become leaders, not alone in health programs, which are vital, but in health, welfare and public programs, then we won't need to worry about socialized medicine.



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1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, Amer. J. Clin. Pathology, *14*:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, J. Amer. Med. Tech., *8*:606-14 (Sept.) 1947.

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MODERN HEALTH PROGRAM

concluded from page 554

of the wealthiest states, we shall not receive what we consider is duly ours in part return for money taken out of Rhode Island by Federal Taxes. Most of the Eastern States fall in this category.

And so Health Programs roll on in keeping with the times and at the same speed. You gentlemen are busy in your chosen profession of caring for the sick and probably have not fully realized the changes in the environment which medical science and social reorientation have brought about in this industrial age and socially minded country of ours. Are you losing prestige and authority in that broader field namely, the social aspects of disease? Is the current trend toward hospitalization of your patients and the desire by your patients of this hospitalization causing you to lose touch with the family, the home, and the personal and economic environments of these patients? If you are losing this home and family contact with your patients social agencies are taking over. As times goes on medical practice will center more and more around the modern hospital. The extensive hospital construction program now coming under way in the United States with its proposed integrated system and close functional affiliation between health centers, diagnostic clinics, community and regional hospitals, will distinctly influence the pattern of medical practice as well as the distribution of qualified physicians. The modern hospital may become the center of extending health education, and preventive medicine will be one of its most important services. In many fields of preventive medicine the Public Health Administrator and the practicing physician can meet on common grounds and with a common understanding and a cordial relationship obtain the ultimate goal of optimum health for the individual and the community. Let us hope that voluntary hospitals and private medical practice will not become history in the United States as they will in England and Wales on our Independence Day, July 4, 1948.

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Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32-241; N. Y. State Journ. Med., Vol. 35, 6-1-25, No. 11, 590-592.

ACUTE ASCENDING PARALYSIS

continued from page 558

any ill effects until the American Army dumped war material in this area in July 1945. The presumption is that the offending agent now rendering the fish poisonous must be some toxin—and that the ascending paralysis produced by eating these fish is on a toxic basis.

There is much to suggest that in contrast to the heterogenous group of etiologies previously mentioned the truly acute form of ascending paralysis that may properly be referred to as Landry's Paralysis may be on some infectious basis. This has been suggested by various writers including Taylor and McDonald[16] who have expressed the opinion that conditions variously termed encephalitis, Landry's paralysis, poliomyelitis, infectious polyneuritis, neuronitis, myelo-radiculitis, and acute benign infectious myelitis are all due to a common infective agent and should be regarded as varying manifestations of one disease.

That the common infective agent in acute ascending paralysis of the Landry type may be a virus has been suggested by several writers although in the present state of our limited knowledge regarding viral disease no definite proof is available. This theory is based upon the fact that Landry's paralysis is usually preceded by what appears to be an acute systemic infection with upper respiratory and gastro-intestinal symptoms. These include sore throat, nausea, diarrhea, great exhaustion, general malaise, and aching of muscles. At this stage of the illness a diagnosis of "grippe" is often made. Temperature and blood counts are usually normal although some cases may have slight fever. Because of this general background which we commonly associate with virus infection, and because of the fact that the paralysis develops quickly at this point, the theory that Landry's paralysis may be a viral disease has been suggested. Whether the virus responsible for the general systemic signs of infection proceeds directly to attack the nervous system as it does in poliomyelitis, or whether this initial virus infection merely activates some already present but hitherto latent infective agent in the nervous system cannot be answered in the light of our present limited knowledge. So much for etiology, let us now turn to the contributions of the pathologist to our knowledge of acute ascending paralysis.

Post mortem studies in the reported cases show such a variety of pictures that pathological diagnosis grossly or microscopically is impossible. In his original monograph Landry stated that one of the diagnostic criteria was an absence of pathologic changes in the nervous system. Subsequent studies however have revealed that this is true in only about thirty percent of cases. The fact that so many cases present no pathologic findings sufficient to explain the widespread paralysis has led to the expression of several possible explanations. One is that since most cases die quickly, the absence of demonstrable lesions may be due simply to the fact that they did not have sufficient time to develop to the extent of being microscopically visible. Another theory is that the paralysis may be due primarily to some difficulty at the myo-neural junction similar to that which occurs in cases of curare poisoning and of botulism where we get quick prostration, extensive weakness, paralysis, and sudden death and yet examination of the nervous system reveals no changes that are pathognomonic. Hassin[17] commenting on the absence of lesions in the central or peripheral nervous system suggests that studies of muscle tissue may reveal significant facts explaining the paralysis.

The majority of cases however do show lesions and these are of such a varied character that it is impossible to assign any specific pathologic picture to this disease. Neither can the pathologic changes in the nervous system be accurately predicted on the basis of the clinical picture presented. A review of the published pathological reports indicates however that the presence of temperature, marked objective sensory disturbances, and loss of sphincter control is generally followed by the finding of definite lesions.

The lesions found in the nervous system range from minimal pathologic alterations to those indicating a severe inflammatory or degenerative process. They likewise vary greatly in location. In a case reported by Dejerine[18] changes were found in the anterior roots while no changes were found in the cord. Drake[19] on the other hand reported a case where the anterior and posterior roots were normal while the anterior horn cells and Clark's column showed mild degenerative changes. Demme[20] reported a case in which the cord showed no pathology except for lymphocytic infiltration of the meninges and in the root entrance zone while the peripheral nerves showed degenration of the axis cylinders.

In some cases, marked pathologic alterations have been found in the cord, brain stem, and brain. Of the changes described in these regions none were specific or common to all. Read, Conley, and Conley[21] report heavy perivascular infiltrations of lymphocytes and plasma cells in the grey matter of the spinal cord and medulla. A number of writers have reported mild chromatolysis of some of the ganglion cells in the cortex.

Thus summarizing the pathologic reports we find that there is no uniformity whatever in either the frequency, severity, character, or distribution of the lesions found. However in most cases where

continued on page 574



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ACUTE ASCENDING PARALYSIS

continued from page 572

definite lesions were found the anterior horn cells or their processes (nerve roots and nerves) were most frequently involved. In a sense therefor one might say that inflammatory lesions akin to those of poliomyelitis predominate. There is nothing specific about the total picture however and the various types of lesions described cannot be logically regarded as different stages of a single process. From this one must assume either that acute ascending paralysis is caused by a variety of agents — or that constitutional or other factors still unknown determine individually different nervous system reactions to a common, perhaps infective, agent. Future research in the field of virus disease may shed light on this subject.

Summarizing to this point it appears that the causes of ascending paralysis in general are many and varied and include those often suggested as the causes of neuritis such as infection, bacteriotoxins, deficiency states, disorders of metabolism, etc. There is also much to suggest that the truly acute form for which the terms acute ascending paralysis or Landry's paralysis should be reserved may be on some infectious and viral basis and perhaps related to poliomyelitis. It also appears that at least one of Landry's original criteria should be revised for the pathologist has amply demonstrated lesions to be present in the nervous system in a high percentage of cases. While not specific, these lesions show certain general characteristics suggesting again that acute ascending paralysis and poliomyelitis may be related.

A typical case once observed is never likely to be forgotten. The first symptom is that of numbness and tingling in the hands and feet. This usually develops within seventy-two hours of the signs of systemic infection previously described. The term ascending paralysis is in a sense a misnomer for an ascending character to the symptoms is not essential to the diagnosis. Thorner, Alpers, and Yaskin[22] in a review of the reported cases found that approximately fifty percent of cases showed a downward progression of symptoms while in some cases the symptoms appeared simultaneously in hands and feet. In any event the parathesias are quickly followed by muscular weakness which progresses to flaccid paralysis with abolition of the tendon reflexes. After involving the extremities the weakness and paralysis affects the abdominal and thoracic groups. Weakness of the intercostal muscles causes difficulty in breathing and paralysis of these muscles may develop so quickly as to cause sudden death at this point. The paralyzing involvement may ascend to produce occular paralysis, aphonia, inability to swallow, and death due to paralysis of vital medullary centers. Characteristically cutaneous and deep sensation remains relatively intact and sphincter control is usually not lost.

The length of time that elapsed from the time of onset to the establishment of the previously described picture of extensive paralysis has been recorded in 87 of the reported cases. In 9% this was twelve hours, in 11% it was from twelve to forty-eight hours, in 31% it was from two to four days, in 33% it was from four to ten days, and in 15% it was longer than ten days.

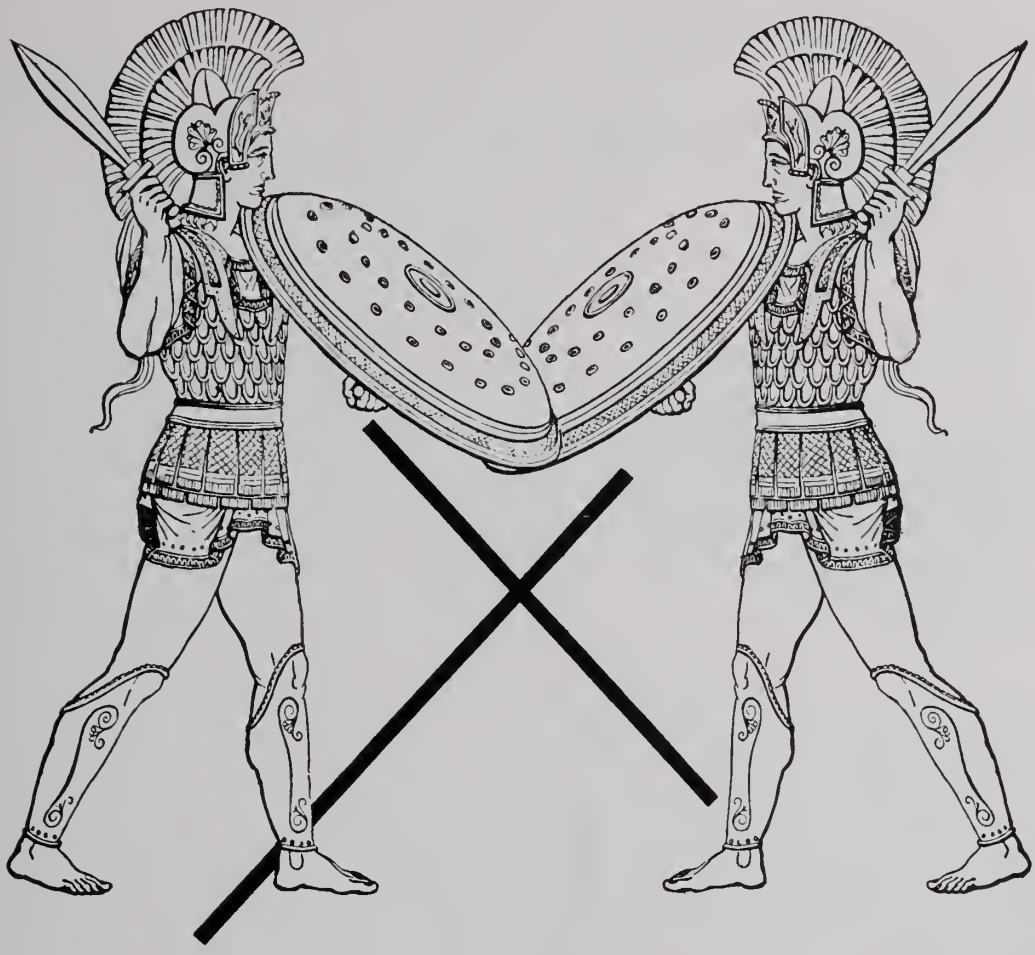
The prognosis must always be viewed gravely. Only about twenty percent survive. Death is practically always due to respiratory paralysis. Hence it is most important that these cases be watched constantly and closely and that a respirator be held in readiness. The use of a respirator however is not always a life saving measure. Its value is greatest where the paralysis is of the respiratory muscles such as the intercostals and due to damage of the anterior horn cells. It is of relatively little value where the paralysis is of the medullary centers themselves. In those cases where there is paralysis of the pharynx with collections of mucous in the respiratory tract the use of a respirator can be definitely harmful.

Those who survive the critical maximum of paralysis may begin their recovery in a few days. It would thus appear that the nervous system is quickly overwhelmed by some pathogenic agent in the beginning of the disease but that if the nervous system is able to survive this initial assault successfully the prognosis is usually good. Recovery in some cases is very rapid and after a few days to a few weeks the patient may be well except for some general exhaustion and sluggishness of reflexes. In other cases recovery may take months. Residual paralyses or muscle wastings do not usually occur. The quick transition in some cases from maximum paralysis to complete recovery in a short period of time suggests that either the pathogenic agent is quickly eliminated or ceases to act, or that certain nervous systems are able to withstand this severe but temporary assault and resist

continued on page 576



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continued from page 574

it before irreversible damage is done to the neurones.

The problem of differential diagnosis is not always easy of solution. The main differential is that between Landry's paralysis, infectious polyneuritis, and acute anterior poliomyelitis. The differential between Landry's paralysis and infectious polyneuritis is practical in terms of the considerably better prognosis with the latter. Differentiation however can be difficult clinically as was originally pointed out by Osler in 1892. In fact the differentiation in some cases may be impossible and it may very well be as is contended by some writers that Landry's paralysis is but a rapidly progressing and highly fatal form of infectious polyneuritis. In the diagnosis of acute infectious polyneuritis much significance is usually attached to the constituents of the spinal fluid. Guillain, Barré, and Strohl[22] first described an elevation of the protein content with little or no increase in cells (albuminocytologic dissociation) often occurring in infectious polyneuritis. This elevation of protein may range from 70 to 1000 mg. or more. Albuminocytological dissociation when present is therefore helpful in distinguishing Landry's paralysis from infectious polyneuritis for in Landry's paralysis the spinal fluid is usually normal. Unfortunately albuminocytologic dissociation is not always present in the early stages of infectious polyneuritis. Some cases of infectious polyneuritis have been reported in which the protein determinations were rather low at the onset of the illness attaining the typical high values only later in the course of the disease. This situation makes the differential between Landry's paralysis and infectious polyneuritis difficult and in some cases impossible early in the course of the disease. In general the findings of a high spinal fluid protein with little or no increase in spinal fluid cell count suggests more an infectious polyneuritis —and this usually means a better prognosis, for while only 20% recover from the Landry type of paralysis about 80% recover from infectious polyneuritis.

Acute anterior poliomyelitis does not usually offer such difficulties in differential diagnosis. Poliomyelitis has a distinct seasonal incidence usually from July to October while polyneuritis and acute ascending paralysis due to viral infection are most prevalent during the colder months of the year. Note that the case herein reported had both attacks during the spring of the year. Poliomyelitis is usually epidemic while polyneuritis is sporadic. Poliomyelitis occurs mostly during the first two decades of life while polyneurtis occurs in all age groups. While in most instances polyneuritis is preceded by an infection the systemic manifestations

continued on page 578

44...

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Nausea and Vamiting

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X-roy sickness
Pregnoncy
Motion sickness

Gostraintestinal Disorders

Cordiosposm[2]
Pylorospasm[2]
Sposm of biliory troct[2]
Spasm of colon[2]
Peptic ulcer[2]
Colitis[3] –
Biliory dyskinesio

Allergic Disarders

Irritobility
To combot stimulotion of ephedrine alone, etc.[3-1]

Irritability Assaciated With Infectians[4]

Restlessness and Irritability With Pain[5,4]

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Chorea
Hysteria
Delirium tremens
Monio

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Traumotic
Tetanus
Strychnine
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Anesthesio

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Induction af Sleep

OBSTETRICAL

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Eclampsia
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ACUTE ASCENDING PARALYSIS

concluded from page 576

of this infection usually subside before the neurologic phenomena appear. Evidences of meningeal irritation are not prominent. In poliomyelitis on the other hand, the systemic manifestations are usually followed rapidly by signs of meningeal irritation and paralysis. Pain in the muscles and muscle spasm is much more marked in poliomyelitis. In polyneuritis the paralysis is usually symmetrical, bilateral, and progressive while in poliomyelitis the paralysis is inclined to be asymmetrical and "spotty." Rarely does ascending paralysis due to polyneuritis involve the hamstrings, gastrocnemius, biceps, and back muscles selectively as is often the case in poliomyelitis. In polyneuritis the cranial nerves are often involved sometimes with a facial diplegia. Involvement of the cranial nerves does not usually occur with poliomyelitis. In polyneuritis the spinal fluid cell count is normal or low while in the preparalytic stage of poliomyelitis the cell count is elevated and falls as the paralysis develops. With polyneuritis the paralysis is apt to develop and progress slowly sometimes over the course of weeks while in poliomyelitis it is rare to have additional involvement after the second week. The prognosis with polyneuritis is generally better except in the very acute and fulminating forms with respiratory paralysis than it is in poliomyelitis where there is apt to be prolonged convalescence with residual muscle atrophy.

A diagnostic pitfall present during the early phase of acute ascending paralysis and one which must be very carefully avoided is the diagnosis of hysteria. In the face of the typical picture of extensive paralysis as previously described one may feel that such confusion of diagnosis is not very likely. Such error does most assuredly occur as is emphasized by the literature which contains many examples. In one series of nine cases reported this error was made three times prior to hospitalization and in one of these cases the diagnosis of hysteria was entertained for a short time even after admission to the hospital. It is noted in the history that this patient had had a psychosis some few years previously. This may have been partially responsible for the error. In still another instance a patient was rushed to the hospital with the diagnosis already made by a neurologist of acute ascending paralysis probably going to require the emergency use of a respirator. At the hospital possibly because of the fact that the patient's history contained a story of a neurotic episode some years previously plus the fact that temperature, blood count, and spinal fluid were normal, plus the fact that although the patient said she could not move her arms or legs a nurse said that she observed some movement of one arm on one occasion, the patient was considered a case of hysteria. Twenty-four hours after admission. her breathing became more difficult. She was given a "placaebo for breathlessness" and left unattended. She was found shortly thereafter —dead. Post mortem examinations showed severe changes in the spinal cord.

On careful reflection error in diagnosis is to a certain extent understandable. The patient complains of sensory phenomena but objective sensory losses are absent. The patient complains of weakness and general prostration yet the thermometer, stethescope, and reflex hammer may reveal nothing definite early in the illness. Blood count and urinalysis are not likely to contribute anything. In substance then we have a patient who complains greatly but shows little or nothing. It is behind these circumstances that the danger of a diagnosis of hysteria lurks. The lesson to be learned is that any person who has recently had or who is having what appears to be a grippe infection and who complains of developing and extending paraesthesias in the distal portions of the extremities is a likely candidate for serious neurological developments. The further lesson is that any such patient should be carefully and frequently checked neurologically —at least every twenty-four hours. Abundant experience proves that a consideration of hysteria without expert neuro-psychiatric evaluation is most dangerous.

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The treatment needs in acute ascending paralysis are approximately the same as those in poliomyelitis. Unfortunately no specific therapy is as yet available. Sulfa drugs and penicillin are of no value except insofar as there may be associated other types of infection. Large doses of vitamins especially thiamin chloride are given emperically. Hospitalization, protection against death due to respiratory failure, and symptomatic treatment are all that we have available in our present limited armamentarium against viral diseases. It is to be hoped that the present intensive research in this field may some day enable us to treat specifically.

Summary

An unusual case of acute ascending paralysis occurring twice in the same individual with complete recovery from both episodes is reported. The incomplete and unsatisfactory state of our knowledge regarding the whole problem of ascending paralysis is discussed in the light of the widely varying etiologies and pathological pictures reported in the literature. It is suggested that a disease entity characterized by a rapidly progressing and highly fatal paralysis does exist and that the term Landry's paralysis or acute ascending paralysis should be properly reserved for this type only. It is further suggested that this type may be of viral origin and related to anterior poliomyelitis and infectious polyneuritis. Causes of other types of ascending paralysis are discussed and the fact that diagnosis and treatment of these other types constitute a problem for the internist as well as the neurologist is pointed out. The symptoms of acute ascending paralysis are described and differential diagnosis discussed. Appreciable danger of an erroneous diagnosis of hysteria during the early phase of the disease is emphasized.

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MEDICAL STATISTICS IN HOSPITALS*

MARY NUNEZ, R.R.L.

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WE ARE ALL familiar with the saying, "Don't put off for tomorrow what you can do today", and the Spanish word, "Mañana", meaning tomorrow. Medical record librarians find that "Mañana", or putting off for tomorrow, is the arch enemy they must help doctors to overcome so that medical records may be completed promptly. We know that medical statistics must be compiled daily so that tomorrow's task may be surmountable and productive of results with the minimum of labor.

All of us are particularly interested in the medical statistics for hospitals outlined in the "Manual of Hospital Standardization" of the American College of Surgeons. The requirements which we are most concerned with are "The Analysis of Hospital Service", and "The Physician's Index", and their relationship to the medical audit of end results. This task requires planning ahead and the limiting of statistics to the essential. I am a great believer in the simple and easiest method and have found it very profitable especially in the great turnover of personnel in the medical record department during the last war and at the present time.

Monthly and yearly statistics are very often made simpler to record by daily noting of the essential data required. I am referring to the recording of the number of patients discharged on each service, deaths, infections, consultations, autopsies, doctors in attendance and departmental data. The attendance of doctors at staff meetings may be kept monthly depending on how often the staff meetings are held. To justify the recording of the above data, a careful analytical review should be carried on by the medical staff at their meetings, interdepartmental conferences and program committee sessions. The medical staff must be aware of the debit and credit aspect of this medical analysis. Results evaluated following careful study and compared with similar reports of other hospitals will elicit whether the results being produced are as good as can be reasonably expected.

In 1946, our medical record committee decided that a chart should be placed in the staff room showing the monthly percentage of incomplete records and unwritten operation descriptions. In 1947, the percentage of autopsies were included. At the end of my talk, miniature copies of these charts will be available for you. We have found it a very successful way of advertising the problem to the members of the staff.

By recording the attendance of active staff members at staff meetings, the interest shown in the professional work may be appraised and proper steps taken for increasing the interest if it is found lacking. If the debit side is on the increase, the percentage of attendance may be compiled for each member and called to his attention. This has proven very efficient in increasing the attendance especially when the requirements of the 75% attendance demanded by the by-laws is insisted upon for a continuation of staff appointment as advised by the American College of Surgeons.

There is no doubt that statistics are indispensable in the preparation of hospital budgets. The administrator depends on these figures to plan for increasing patient loads, equipment, new drugs, prediction of necessary expansion, and other pertinent measures necessary for the well being of the patient. The value of medical statistics is dependent on the complete and adequate records of each patient. Essentials should be determined and adhered to. There has been a great improvement in the quality of medical records in the past five years at our hospitals. They are completed more promptly and accurately. There is still room for further improvement but strides in the right direction have been made and are very noticeable. Our staff is much more record conscious, and as I talk to other medical record librarians who have been in this field for fifteen to twenty years, they have noted this improvement in their hospitals, too. There seems to be no question that the existence of adequate medical records supported by accurate statistics has aided greatly in the advancement of treatment and development of new procedures to the ultimate benefit of the patient.

continued on page 582

* Presented before the Massachusetts Association of Medical Records Librarians, at Boston, Massachusetts, April 28, 1948.



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MEDICAL STATISTICS IN HOSPITALS

continued from page 579

The physician's index as outlined by the American College of Surgeons is for the purpose of estimating the efficiency of the individual physician practicing in the hospital and is a statistical method of evaluating the competence of the members of the medical staff. This index may be simple or elaborate depending on the individual needs of the hospital and its budget. It loses its merit if the medical record is not completed promptly and is entirely dependent on the full cooperation of the medical staff for accurate results. An important phase of this index is that the physician immediately on admission of a patient and following his examination should determine whether the treatment is elective, emergency or palliative, and whether the risk is good, fair or bad, and note it on the chart at that time. The admission diagnosis should also be recorded promptly on admission. This information is then compared with the result secured and analyzed by a qualified medical committee or medical authority. This record is an extremely confidential one. Any physician may be shown his index, and it may be accessible to the credentials committee for evaluation when making recommendations for future appointment, but the committee must have an appreciation of the confidential nature of this record.

The questionnaire which is being introduced by the American College of Surgeons, for the appraising of hospitals, contains requests for additional statistics, which are not included in the "Analysis of Hospital Service" form. The following are some that I have noticed:

"Average daily census: Bed capacity: %
Postoperative deaths: Number of
(Death within 10 days) operations: %
Caesarean section rate: Viable births: %
Sections:
(The average of 2-3% is the expected normal rate.)"

These additional items should be considered in planning statistics for the future so that this information may be readily available for study.

There are many suggested aids in keeping stastics and the individual hospital should ascertain which method is best for the particular hospital. Statistics may be kept in loose leaf books, vertical card files, visible card files, punched card system, with its accompanying key punch machine, tabulating machine, and card counting sorter, or the



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more simplified McBee Key Sort Machine method. The hospital budget will have to be considered. At our hospital, the business office has been using the McBee Key Sort Machine method for several years. In the medical record department, we have found the vertical card file system to be satisfactory. We use the forms of "The Analysis of Hospital Service" for our monthly reports. These different methods are described in detail in the textbooks, "Manual for Medical Records Librarians", by Hoffman, and "Medical Records in the Hospital", by Dr. MacEachern. Also, in the bulletins of the American Association of Medical Records Librarians, articles have appeared, denoting individual opinions of advantages and disadvantages of the different methods in use.

I have tried to cover the major points with reference to minimum medical statistics required and their importance. Accurate medical statistics are not possible without the complete cooperation of the medical staff in keeping prompt medical records containing essential facts. The word, "Mañana," may be used in its proper sphere but not in procrastinating the completion of medical records. The method of keeping these statistics will vary with the individual need of the hospital and its budget and can best be determined by careful study. Daily recording of statistics is most important to consider in facilitating the keeping of monthly and annual reports.

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Druggists and the medical profession were urged today by the Federal Security Agency's Food and Drug Administration to return all stocks of Siliform Ampuls to the manufacturer, The Heilkraft Medical Company, Boston, Mass. This injection drug, which should be sterile, is potentially dangerous since samples collected on the market contain living organisms. Siliform is injected by some physicians and osteopaths in the belief that it will relieve patients suffering with rheumatism as claimed by the manufacturer. The Food and Drug Administration found the contaminated samples after a routine inspection at the Heilkraft factory disclosed that the Siliform Ampuls had been manufactured without sterilization. Intensive recall efforts by the manufacturer and the Food and Drug Administration for the past two weeks have not brought in all of the contaminated stocks. The article, which moves slowly, was shipped to 37 states from Maine to California and later was redistributed by wholesalers who cannot trace many of their sales. Some going back as far as 1946 have been found on the market. These ampuls may be in the hands of doctors, hospitals, clinics, and retail and wholesale druggists.



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WANTED BY THE FBI

HUGO BOB HUBSCH, with aliases Robert C. Glass, R. C. Harris, Hogo Hobsch, Louis S. Miller, is being sought by the Federal Bureau of Investigation. On November 7, 1945, a Federal Grand Jury at Jackson, Mississippi, returned an indictment charging this man with a violation of the National Stolen Property Act. He is charged with another violation of the National Stolen Property Act in a complaint filed with a U. S. Commissioner at Birmingham, Alabama, on June 7, 1948. This individual has defrauded numerous physicians and hospitals in Eastern and Southeastern sections of the United States during the past few months through the medium of fraudulent checks.

Investigation has revealed that HUBSCH has a chronic kidney ailment and it has recently been ascertained that he has a large kidney stone in the right ureter about four inches below the kidney. This condition has caused local inflammation which, at varying intervals, results in almost unbearable pain. He has been advised that it would be necessary for him to undergo major surgery for the removal of the stone in the near future and until that surgery is performed he will need frequent, if not continuous, medical attention. This fugitive moves about rapidly in that section of the United States which is East of the Mississippi River and recently he has given numerous physicians and hospitals fraudulent checks in return for treatment, hospitalization, sedatives and narcotic prescriptions.

The following is a composite description of HUGO BOB HUBSCH: Age, about 52, claims to have been born Budapest, Hungary, November 4, 1895; height, about 5'-6"; weight, 140 to 170 lbs.; hair, dark brown, graying; eyes, brown; build, medium; race, white; nationality, believed to be naturalized American; occupations, laborer, pharmacist; scars and marks, left arm partially paralyzed, needle scars on both arms, large scars above each hip resulting from kidney operations, shrapnel scars and two bullet scars on abdomen, bridge in upper front teeth; characteristics, long nose, stooped posture.

Anyone having information concerning the whereabouts of this fugitive should immediately notify the nearest office of the Federal Bureau of Investigation or your local law enforcement agency.



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INDEX OF ADVERTISERS

	PAGE
Abbott Laboratories	577
Alkalol Company	574, 584
American Meat Institute	Inside front cover
Ames Company, Inc.	570
E. P. Anthony, Inc.	587
Ar-Ex Cosmetics, Inc.	583
Arlington Chemical Company	568, 582
Ayerst, McKenna & Harrison	541
Bayview Convalescent Home	570
Blanding & Blanding	546
J. E. Brennan & Company	587
George A. Breon and Company	581
Joseph Brown Company	584
Butterfield Drug Stores	545
Camel	543
S. H. Camp Company	540
Ciba Pharmaceutical Products, Inc.	469, 533
Curran and Burton	584
Edgewood School	583
J. E. Hanger, Inc.	545
H. P. Hood & Sons	537
Eli Lilly & Company	Insert beteewn 546-547
McCaffrey, Inc.	587
McKesson & Robbins, Inc.	534
Mead Johnson & Company	Back Cover
Medical Milk Commission	581
A. B. Munroe Dairy	576
Mutual Benefit Health and Accident Association	586
S. E. Massengill Co.	569
Narragansett Brewing Company	588
National Drug Co.	536
Neland Pharmaceutical, Inc.	538
Parke, Davis & Company	Inside back cover
Philip Morris & Co. Ltd.	571
Physicians Directory	544-545
Rhode Island Limb Company	538
Schering Corporation	573
G. D. Searle & Company	565
Sharpe & Dohme	567
Smith-Holden, Inc.	585
E. R. Squibb	535
Strand Optical Co.	587
Tilden-Thurber	545
Upjohn	575
Warwick Club Ginger Ale Co. Inc.	538
White Rock Bottling Company of Rhode Island	578
Winthrop-Stearns, Inc.	542

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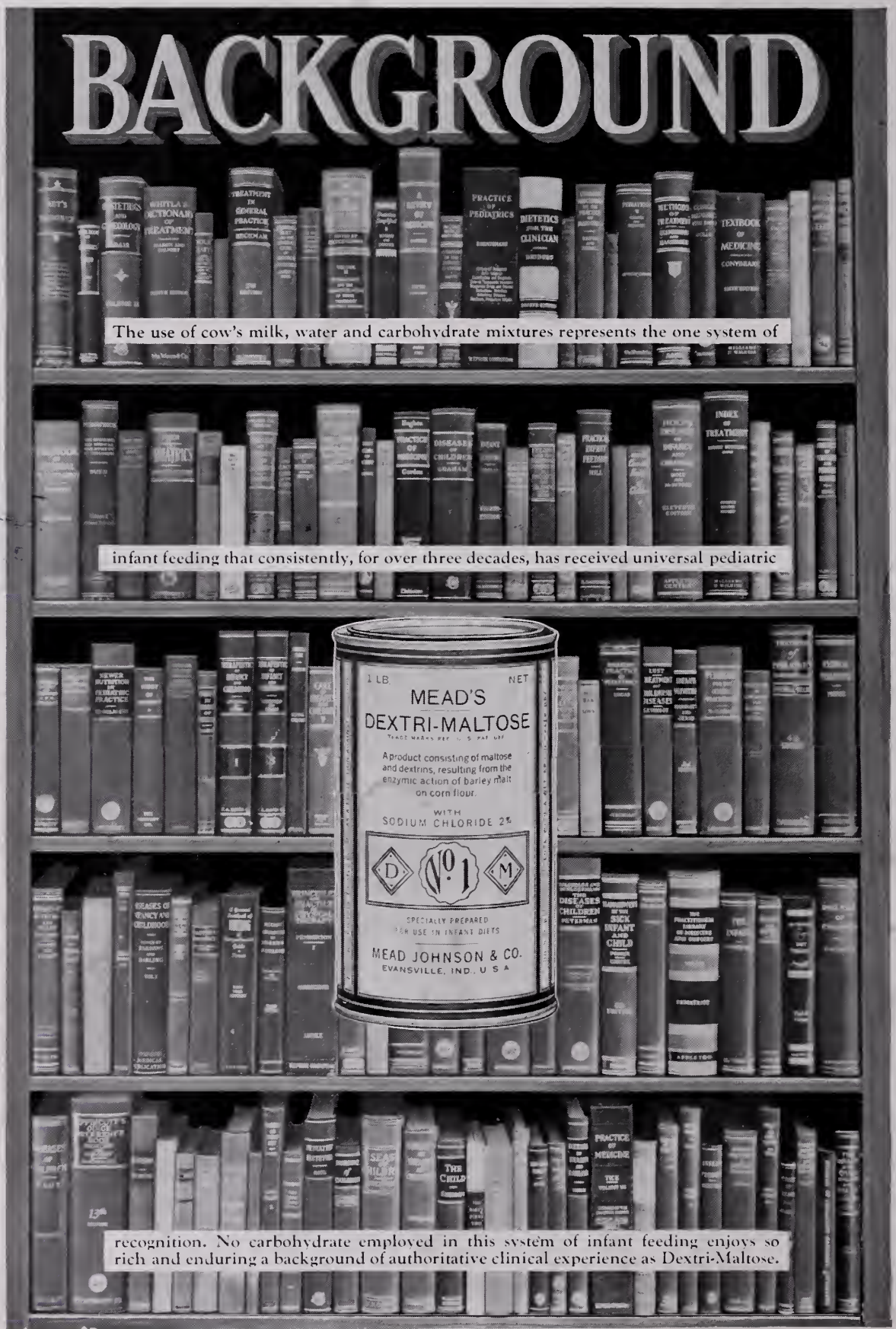
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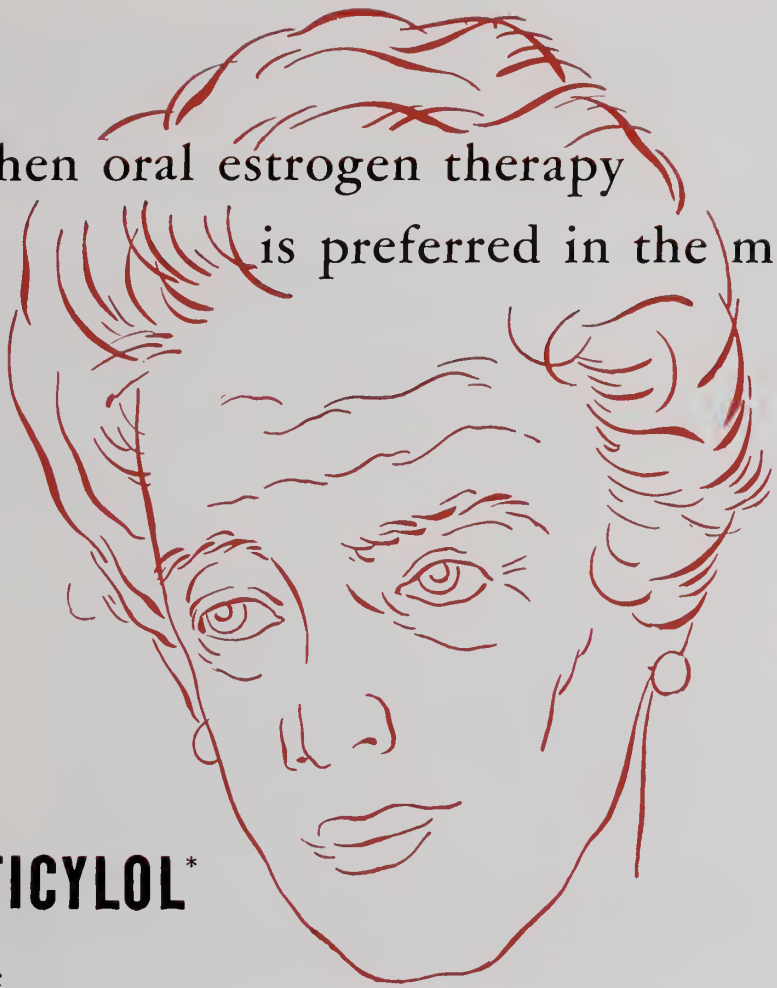
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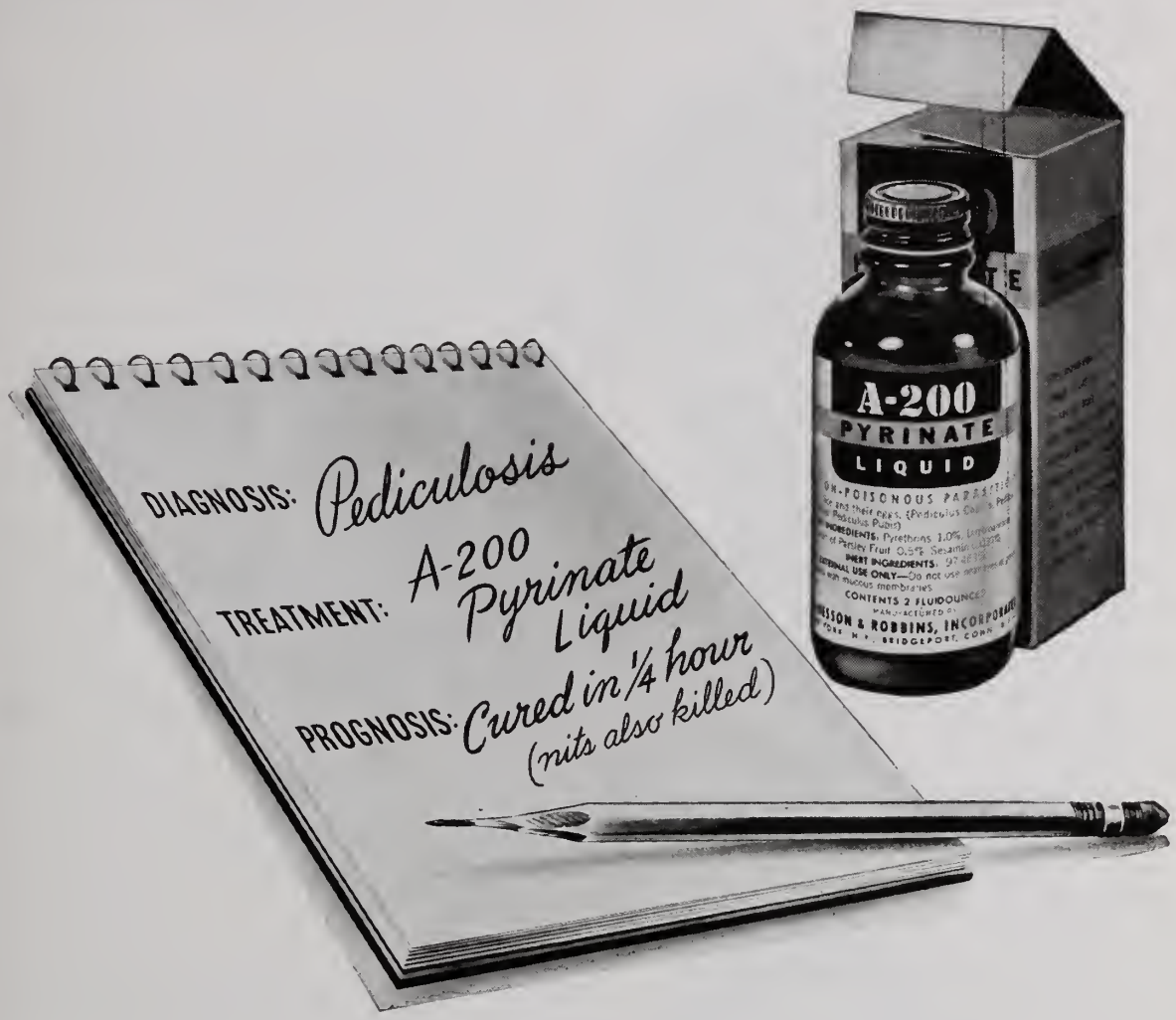
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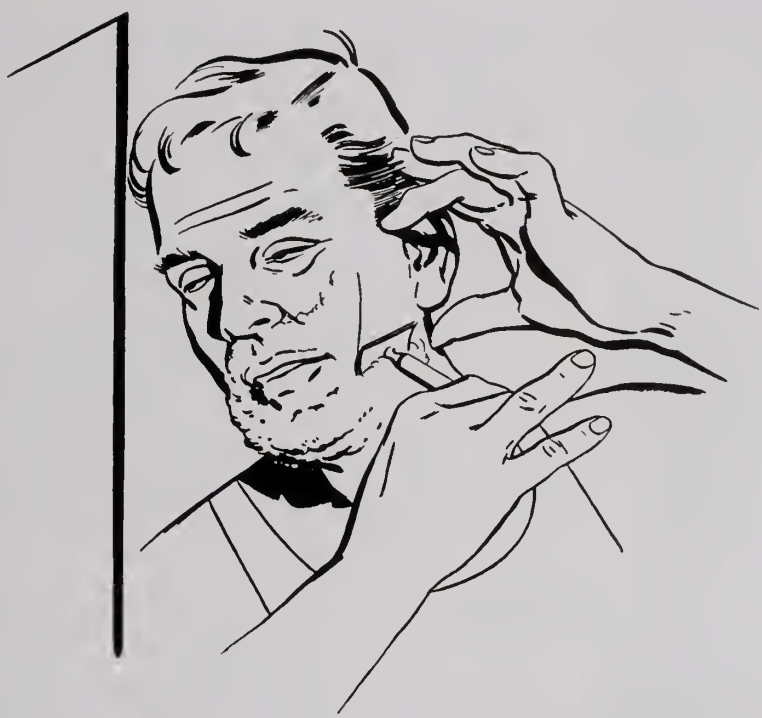
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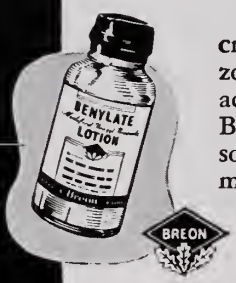
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Vol. XXXI, No. 10 October, 1948

TABLE OF CONTENTS

PAGE

Effective Procedures in the Treatment of Injured Hands to Prevent Crippling Deformities, *William E. Browne,* M.D. 603

Pneumonia Not Responding to Penicillin, *Morgan Cutts,* M.D. 609

The John F. Kenney Annual Clinic, Program 614

Cancer Conference for R. I. Physicians, Program 619

Roster of Fellows, R. I. Medical Society 620

EDITORIALS

The National Mental Health Act 612

John E. Ruisi, M.D. 613

MISCELLANEOUS

Book Reviews 638

Medical Library Notes 616

New England Postgraduate Assembly, Program 643

Statement of Ownership, R. I. Medical Journal 613



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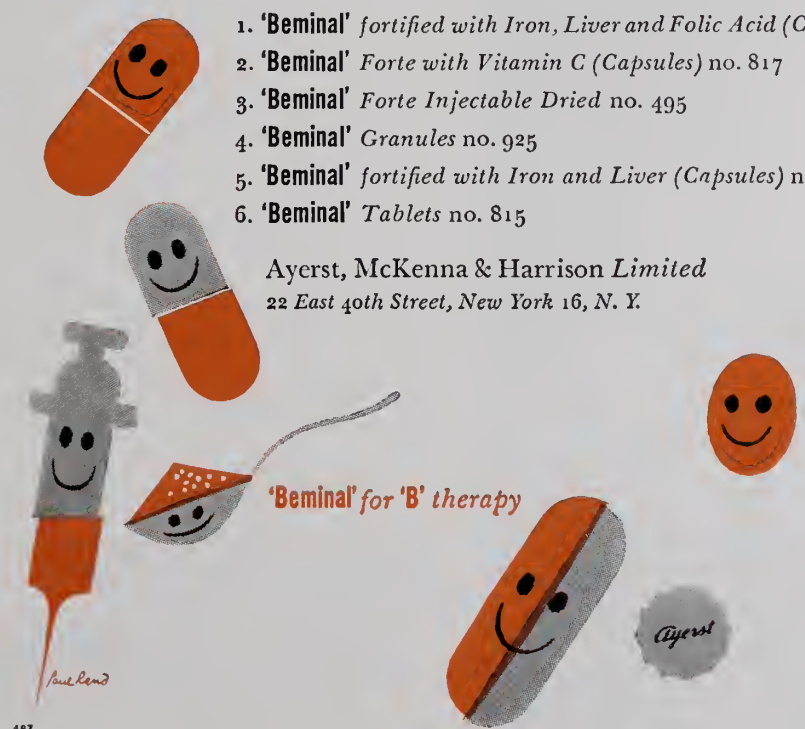
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1. Follis, R. H., Jackson, D., Eliot, M. M., and Park, E. A.: *Am. Jour. Dis. Child.*, 66:1, July, 1943.
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EFFECTIVE PROCEDURES IN THE TREATMENT OF INJURED HANDS TO PREVENT CRIPPLING DEFORMITIES*

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SERIOUS permanent dysfunction may follow injury to any of the structures of the hand. A small laceratoin involving the skin and underlying fat with ensuing infection may result in a crippled finger. That fact is so obvious that mentioning it is really unnecessary. It is equally obvious that wounds of the hand must be made clean or infection will result. These infections have not materially lessened in number since the advent of sulfa drugs and penicillin. These remedies are valuable in controlling infection after it has developed. Making clean a potentially or actually infected wound of the hand will, in 97% of hand injuries, prevent infection. Cleansing a wound is a prime requisite in the management of wounds in other parts of the body, and certainly in the management of wounds of the hand. After cleansing, removal of devitalized tissues and those which will become devitalized must be done before a wound of the hand may be closed.

Diagnosis of Injured Structures

A correct diagnosis of injured structures is necessary in order that adequate treatment may be carried out. Correct diagnosis demands a knowledge of the anatomy of these structures and their functions; a knowledge of the layers of the skin which, unbroken, is highly resistant to infection; a knowledge of the gross and microscopic anatomy of tendons and nerves and blood vessels, and the healing of these structures after injury. It is necessary to know of benign and malignant growths because at times growths of one kind or another are encountered in the management of wounds of the hand. Effective measures widely but not uniformly and routinely used in the management of a bad laceration of the hand may well be set forth in the consideration of a hypothetical patient — let us say a twenty-eight year old male employee — who was injured at ten o'clock this morning. His hand was caught and pulled in forcefully between a rapidly moving wire rope and a pulley. He was seen within a few minutes by a well trained nurse in the first aid room of the plant. She at once noted the wound was not bleeding very badly, and she covered it with sterile gauze. It involved the radial side of the wrist, and it extended obliquely distalward up onto the thenar eminence. There was a superficial prolongation of the wound toward the ulnar side of the wrist. She said the wound appeared jagged and deep. A pressure dressing was put on by her and the man was sent to the hospital. There in the accident room brief but adequate questioning revealed he was in no great pain. He did feel a little faint. He had never had fainting spells. So far as he knew, he was in good health. A specimen of urine examined after admission to the ward was negative for tests for albumin and sugar. He had been in the last war and understood, following a puncture wound of the foot, he had been given a "shot" to prevent lockjaw. That was four years ago. No subsequent "shots" had been given him. He had never had epileptic or other convulsive seizures. The accident happened in the shipping room of a machine shop. In the accident room at the hospital this "pressure" dressing which had been put on by the nurse was not disturbed. Some blood had leaked into the outer layers of it, but it was not soaking wet with blood. The distal phalangeal portion of the thumb and distal and mid phalangeal portions of other fingers were visible beyond the end of the dressing. The front of the thumb felt numb. He could not flex the interphalangeal joint of it. When passively flexed, against slight resistance he could extend it, but not fully. He had

continued on next page

*Presented at the 137th Annual Meeting of the Rhode Island Medical Society, at Providence, R. I., May 12, 1948.

questionable opponens function. The opponens pollicis muscle, supplied by the median nerve, in large part enables one to forcefully touch the tip of the thumb to the tip of each of the other fingers.

As already stated, the anterior surface of the thumb felt numb and he could not flex the interphalangeal joint. He could not flex either interphalangeal joint of the index finger. Sensation on the radial side of the part of this finger protruding beyond the end of the dressing was markedly diminished or absent. Protruding portions of other fingers functioned all right, except spreading the fingers apart and bringing them together was not possible because of the dressing. When this accident happened, he said he thought he heard something like a shot and wondered if a bone had been broken. Without disturbing the dressing at all, from the story given by him and from the physical examination thus far made, a diagnosis was made of damage to the long flexor of the thumb and to both flexors of the index finger; also a diagnosis of possible damage to motor and certain damage to sensory branches of the median nerve. Operation would be necessary and he wanted it done.

Preparation for Operative Procedure

Operation would be done in the operating room where any major surgical procedure is carried out, and this is a major surgical problem. An anesthetist would be necessary. The choice of anesthesia had best be gas ether or ether alone, and not brachial block or peripheral block or local infiltration anesthesia. Other anesthetics could be used, but gas ether would assure satisfaction. On the way to the ward an x-ray picture would be made and the film would be available very shortly. In the ward his blood pressure was found to be 100/80; heart sounds were clear; no murmurs heard; pulse rate 84; no abnormal chest sounds were heard; respirations 28 per minute; his temperature was 98 deg. F. The laboratory technician obtained blood and a report of examination of this (though not a detailed examination) showed nothing which would contraindicate respiratory anesthesia or surgery.

The patient was transferred to the operating room, having first been seen by the anesthetist. He had ready a blood pressure cuff which had been tested and which did not leak, and this was applied about the upper arm without wrinkling the skin. Over this cuff, to hold it securely and evenly, several turns of a cotton bandage were taken. Two hemostats, with rubber covering on the jaws of these, were on the table beside the anesthetist. Later on, after the arm had been elevated for three minutes by the clock, the blood pressure cuff would be inflated and the rubber tubes from the cuff would be held securely with these rubber-covered clamps which would be applied by the anesthetist. A large metal tray with an outlet attachment for irrigation purposes was ready. A large container of sterile, warm water was available. The x-ray film was brought in and no fracture was found.

Personnel, Light and Instruments

Proper instruments for handling delicate structures of the hand were ready, and also instruments for removal of skin for grafting. It is important to have suitable instruments for adequate and safe handling of these delicate structures within the hand. A graduate nurse with student assistant, the anesthetist, an intern, a resident, and a surgeon responsible for the operative procedure to be undertaken, are ready to do anything which should properly be done for the repair of this hand. The man was injured a little less than two hours ago. With safety, therefore, so far as the time element is concerned, an extensive procedure may be carried out. Had he been injured eight or ten hours ago, tendon and nerve suturing would not be carried out as a part of this primary operation.

Further Examination Before Cleansing The Wound

The bandage and that part of the dressing outside layers of gauze covering the wound itself, are removed. It is noted he has no real opponens action. The functions of structures supplied by the radial and ulna nerves are evaluated. He can abduct the thumb one-half normally. Abduction is mediated not only through the radial nerve but in part through the median. Adduction is carried out fairly well. The important function of adduction of the thumb depends largely on the adductor muscle which is supplied by the ulna nerve. He can separate the fingers and bring them together side by side. Sensation on the back of the hand and on the palmar aspect of the fifth and part of the fourth fingers is present. It is equivocal as regards the third finger. The interphalangeal joints of the third, fourth and fifth fingers and the metacarpophalangeal joint of each of these fingers function just about normally. The first and second lumbrical muscles are supplied through branches from the median nerve, and the third and fourth through the ulna nerve. These muscles, not entirely, but in considerable degree, flex the proximal phalanx of the second, third, fourth and fifth fingers. The gauze which was put on by the nurse directly over the wound itself has thus far not been disturbed. The hand and forearm are covered with towels and are held by the intern. The anesthesia is started. The arm is held elevated three minutes by the clock, and then the blood pressure cuff is inflated to 280 mm. of mercury. The arm is lowered. The towels are removed. The surgeon and resident have on gowns and rubber gloves, and cleansing of the

wound is started. Sixty to eighty quarts of warm, sterile water are available, together with bland soap and fine mesh gauze or cotton. About this amount of water for cleansing and irrigation purposes will be needed. The wound itself is uncovered. It is four inches (about 10 cm.) in length. The edges of it are an inch (about 2.5 cm.) apart, and these edges are jagged. The wound itself is again covered with sterile gauze. All surfaces of the hand and forearm except the wound are washed with soap and water which is poured slowly from a container. Hair on the dorsum of the hand and fingers and on the forearm up to the elbow is shaved. Ten minutes are spent in cleansing areas about the wound, and then the wound itself is uncovered. Ten minutes are spent in gently and adequately cleansing this large, gaping wound. No foreign bodies are felt. The blood pressure cuff is deflated, and the amount of free bleeding is noted. The wound is again covered with gauze. Sterile towels are applied. The arm is elevated. The blood pressure cuff is inflated. The surgeon and resident who cleansed the wound have changed gloves and scrubbed, and now actual operative procedures may be started. Further inspection of this wound reveals in about the center of it a shiny, white structure which is a tendon. Lateral to this, toward the thumb, a somewhat yellowish-brown and not glistening white structure is seen, and this structure is identified as a tendon. It is ragged. Two inches of it are readily seen, and the change from normal in the color of it is particularly noted.

The first procedure necessary for the prevention of crippling dysfunction in his hand was to convert this contaminated wound, this potentially and perhaps actually infected wound, into a clean one. This has partly been done. Iodine was not poured into the wound nor any other strong antiseptic solution. Antiseptic solutions, what few there are which will not irritate or further traumatize tissues, may be used. The use of these, however, is not necessary if the wound has been adqeuately cleansed with a bland soap, lots of soapsuds and warm water applied with cotton or fine mesh gauze. No scrubbing brush is used in this cleansing process. No matter what further operative procedures may be undertaken, one must be, and that is making a closed wound of this open one. It has already been noted that it cannot be made a closed wound until devitalized tissues or tissues which will shortly become devitalized are removed with a sharp knife or a sharp-bladed scissors — scissors which will cut and not further crush tissues.

Debridement and Enlarging The Wound

Viable muscle is recognized by its color. Later in this procedure, when the blood pressure cuff is deflated, viable muscle will be found to bleed. Nonviable muscle is recognized by its purplish-red or deep purple-red color and no bleeding from it. Tendon sheaths which are ravelled will quickly lose blood supply. At best aseptic necrosis will follow, and this may lead to infection. Viable tendons are shiny in appearance. Tendons which have been avulsed and pulled and stretched quickly lose their blood supply and change in color. Divided tendon ends retract. Freshly divided nerves do not retract markedly, so that the ends cannot be drawn together nicely provided there has not been an appreciable loss of nerve tissue. A normal nerve is somewhat grey in appearance and dull and not shiny, as is a tendon. The cut end of a healthy, viable nerve bleeds. A tendon and nerve lying side by side differ in appearance. This point alone, if remembered, will aid in the prevention of suturing, for example, the proximal end of a divided median nerve to the distal end of the palmaris longus tendon.

This wound is step by step debrided. This is not a mass debridement. Small segments are removed down to viable tissues. Up to now the wound has been cleansed, and conservative but adequate debridement has been carried out. All parts of the hand and wrist not in the operative field are covered with warm, moist, saline pads. Two large rubber bulb syringes are available, and tissues throughout this procedure will be kept moistened with warm salt solution. The wound itself is further explored. Enlargement of it is found necessary. It is noted that the part of the wound extending toward the ulnar side of the wrist had not gone far enough to involve the ulnar nerve. This nerve lies above and crosses the wrist somewhat diagonally anterior to the anterior carpal ligament. The palmaris longus tendon is identified, and somehow it had not been divided. The long tendon of this muscle may be used at times for a tendon graft. The median nerve, just beneath this tendon at the level of the wrist is identified, and found at this level to be intact. The wound is not enlarged by a mid-line incision extending from the wrist partway up the forearm. It is enlarged by a linear incision along the ulnar aspect of the lower forearm and thence across the wrist at the level of the natural crease marks still present in the skin on the ulnar side. In the palm it is enlarged a little, close to the natural crease mark mesial to the thenar eminence. A definite diagnosis had been made before operation of damage to the long flexor of the thumb and both flexors of the index finger; a diagnosis of injury of sensory branches of the median nerve and possible motor branches had been made. The median nerve is traced down to the anterior carpal ligament, which is a very dense structure. It too had been somewhat injured but not completely divided. It is necessary to divide it in order to thoroughly explore the median nerve which is beneath it. The

continued on next page

carpal ligament is divided toward the ulnar side of it, and enough of it is left so that the edges may be sutured later on, and the scar following repair of the ligament will be away from the underlying median nerve and tendons which may be sutured. In the debridement of skin and muscle bundles of the thenar eminence, it was noted that part of the flexor brevis pollicis had been injured and also the abductor pollicis. This latter muscle pretty well overlies the opponens pollicis, and this structure, on examination of it, was found pretty nearly intact. The median nerve is now well seen. The epineurium of it is grasped gently with fine forceps, and the nerve is elevated somewhat. Just anterior to the distal edge of the carpal ligament, a nerve the size of an ordinary wooden toothpick in diameter and coming off the main trunk of the median nerve nearly transversely or silghtly obliquely is found divided. This division is very close to the main trunk of the nerve. This is recognized as an important motor branch. To the ulnar side of it two other nerves are found divided. These probably are sensory nerves but may include filaments which ennervate the first and second lumbrical muscles. Careful handling of the nerve coverings and mobilizing these nerves permit nerve ends to be brought together very well. Definite nerve bundles within the epineurial sheaths are easily seen. Very fine silk sutures on atraumatic needles will be used in the epineurium to bring the nerve ends together, and sutures will not go through nerve bundles. The end of the tendon which was noted changed in color is definitely identified as the proximal end of the flexor longus pollicis tendon. This is the only structure which can flex the distal phalanx of the thumb. The distal end of this tendon is found without difficulty. The proximal end is frayed and jagged, and the tendon sheath is torn and absent in two or three places. Next, the ends of the divided flexor tendons of the index finger are found. The laceration in the sublimis tendon is proximal to the point where the tendon divides; the laceration in the deep tendon is proximal to that in the sublimis. The first and second lumbrical muscles are identified. Lumbrical muscles are found without difficulty. Each of these four muscles is attached proximally to a deep flexor tendon. The divided ends of the flexors of the index finger are separated between one-half to three-quarters of an inch (about 1 to 1.5 cm.). These ends can be brought together without undue tension and without undesirable full flexion of the finger. Both the superficial and deep flexor will be sutured. The ends of the divided flexor of the thumb could not possibly be brought together after resection of non-viable portion of this tendon. It is remembered again this man's hand was wedged between a moving wire rope and a pulley. It is always important to know how the accident happened and where; a relatively clean machine shop or an accident on a tractor on the farm. The operative procedures carried out thus far, including the washing of the wound and debridement, have taken an hour and a quarter. After the blood pressure cuff is deflated, twenty minutes or more will be required for meticulous ligation of all bleeding points. A skin graft is necessary in order to safely close this wound. It will take most of an hour for removal of skin from the thigh and attaching it to the skin edges in the hand. Forty minutes may be required for suturing nerve coverings and for suturing the tendons of the index finger. Fully three hours, therefore, will have gone by before operation is completed. The blood pressure cuff will have been on the arm and inflated to 280 mm. of mercury most of that time. That is perfectly all right. It is unnecessary, if the blood pressure cuff was applied properly, to deflate it at the end of an hour or two hours. An ordinary blood pressure cuff is used. A canvas-covered, narrow cuff with zipper attachment is not used, nor is a piece of rubber tubing. Frequently in the course of a year an inflated blood pressure cuff remains on the arm for three or four hours in reconstructive, operative procedures and without harm to tissues.

Approximation of Viable Ends of Divided Structures

The flexor tendons of the index finger are sutured. Many fine silk sutures are taken in the covering of nerves, and the ends of these are brought together. No attempt will be made at this operation to establish continuity of the long flexor of the thumb, important though it is. A tendon lengthening procedure would not be satisfactory. A tendon graft would be the best procedure. Possibly the palmaris longus tendon could be used. A peroneal tendon from the foot could be used better to fill in this marked defect in the flexor longus pollicis. Adequate blood supply is necessary for primary wound healing. Adequate blood supply of a tendon is very necessary for good tendon healing. This is not only true in the so-called "ordinary tendon suture cases," but it is certainly true as regards healing of tendon grafts. Timidity is not the deterring factor in decision against attempt to repair the flexor longus pollicis tendon. If a tendon graft were carried out and if, as very well might happen, inadequate blood supply resulted in aseptic necrosis or some degree of slough, then the work already satisfactorily carried out on nerves and the tendons of the index finger would terminate in a very unfortunate end result. It is, of course, recognized that the sooner after injury structures are properly brought together, the better the end result will be. It is also recognized that doing more than must be done or more than can safely be done will

end with serious dysfunction. A tendon graft, when carried out as a separate elective procedure, in not better than one-half of our tendon graft cases, results in a one-half to two-thirds normally functioning finger — never a perfect result — and in something less than one-half of the cases, the end result is not better than a one-third normally functioning finger. In four of our cases the end result following tendon graft has been a finger with no usable motion in it. The reasonably good end result which we have a right to expect in this case following nerve and tendon suturing might very well be jeopardized were a tendon graft procedure carried out on the flexor longus pollicis tendon.

Knowledge of how these injured tissues heal and the necessity for adequate blood supply precludes the use of any foreign substance about the level of any of these sutures lines, substances such as strips of tantalum or vitallium. The type of tendon suture which may be decided upon is the type which works best for the experienced surgeon who is doing the work. One cannot say that wire sutures should be used in a great percentage of the cases or that nylon sutures should be used entirely. One can say that catgut should not be used for tendon suturing. Our experience has shown that silk sutures are very dependable.

Thus far in this man's case the wound was:

1. Adequately cleansed.
2. Adequately debrided.
3. All work was done in a bloodless field.
4. Ends of divided structures were not brought together under tension, nor was it necessary to place the index finger in a position of such forced flexion that return to usable function would not follow.
5. The divided ends of the flexor longus pollicis tendon were not sutured to adjoining structures. They were allowed to lie naturally. They may, without difficulty, be found if and when further operative procedure is undertaken.
6. Upon completion of suturing, before attaching the skin graft which was obtained from the thigh, the blood pressure cuff was deflated and bleeding points were meticulously ligated.

Types of graft for filling defects in wounds differ in different cases. At times in the palm a rope graft is necessary. Some very competent surgeons have found that a rope graft may be carried out as a part of primary operataion. A rope graft was not found necessary in this case. Very rarely in our hands is a rope graft made a part of a primary surgical procedure aften tendon and nerve suturing. In this man's case an intermediate thickness graft of skin was applied. If a rope graft had been considered desirable in this case, it would not have been done as a part of primary operation. Possibly a further operative procedure will be necessary for restoration of a usable degree of function in the thumb.

It is stated again at the risk of being unnecessarily repetitious — a contaminated wound must be made clean; an open wound must be converted into a closed one. Other procedures, depending upon the condition of tissues injured and methods available for establishing continuity of these tissues, may and should be carried out when safety permits. It is not advisable in a certain percentage of badly lacerated hands to attempt repair of all injured structures at the first operation.

The Dressing

It is correct to say that the application of the dressing ranks in importance with operative procedures. Adequate hemostasis, ever so carefully attended to, and a proper pressure dressing, will prevent hematoma formation. Hematoma might be followed by infection or in any event would prevent primary wound healing. The dressing on this man's hand is very carefully applied. Fluffed gauze is packed carefully between the fingers and on the palm and on the dorsal aspect of the hand. This is reinforced with machinists' waste or sea-water sponges used outside the fluffed gauze. This dressing assures even pressure which is necessary. Strips of vaseline gauze or other materials which may cause skin maceration are not used. In all probability, this dressing applied today will not require removal for ten to fourteen days. The fingers, other than the index finger, are allowed to rest, as far as possible, in physiologically functioning position. The index finger is held securely in flexion. Immobilization of the elbow joint in certain cases, and in this case, is necessary. After the dressing is applied, the extremity must be rested on a properly padded splint. It may be made of wood or aluminum or a plaster of Paris mold. An aluminum splint made to fit this patient's forearm and hand would be ideal. It does not, however, make too much difference as to the materials of which a splint is made. It does make great difference as to how a splint is applied.

The anesthetist, during this procedure, attended to the administration of glucose solution. He accompanied the patient to the ward. Post-operative orders were written including tetanus toxoid and further blood examinations. His condition will be watched carefully and blood, if necessary, will be administered. Following a lengthy hand operation, a patient may show signs of shock. The surgeon, or someone well trained and who knows the importance of detail, will see to it that this arm is maintained properly elevated for three or four days. It must be so elevated that at no time does it become dependent with ensuing edema, which would prevent healing of the wound or certainly delay it.

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The dressing may be changed in four or five days, if one wants to be sure that there is no maceration of skin edges which would also delay wound healing. It will have to be changed if he complains of pain which persists or is throbbing in nature. A temperature of above 99.6 F. or any throbbing pain would not be expected in this case. As already noted, this dressing applied today probably will not be removed for ten to fourteen days. The dressing may be changed in the ward or in a room set apart for dressings. A mask should cover the surgeon's nose and mouth when the first dressing is done. Quite often it is necessary to come pretty close to the hand in order to see and remove fine sutures in the skin. One should not breathe into this healing wound. Knowledge of how tendons and nerves heal would not permit this man's fingers or wrist being moved for three weeks' time. At the end of four weeks he will be instructed by the surgeon what motions may and what motions must not be carried out. After removal of the splint at the end of four and a half to six weeks, he will be instructed how to apply the splint or have it applied during sleeping hours. At times, when the patient is asleep, an unprotected hand may be injured.

It is recognized that some competent surgeons, in the handling of this case, would entirely disagree with the treatment of the injured long flexor of the thumb.

In this case we would expect primary wound healing, no edema and no infection. We would expect pretty close to two-thirds return to normal function in the index finger. We would expect return of sensation to the sides of the thumb and index finger. We would expect one-half to two-thirds return of motor function. Sensation should become normal in the third finger . We would explain to this patient how he might get along fairly well though unable to flex the joint of his thumb. Flexion of the interphalangeal joint of the thumb aids in opponens action. A tendodesis could have been done as part of this procedure. That would result in a permanently, partially flexed position of the distal phalanx. This in turn would make more useful his thumb as a whole than with the thumb in straight angle position or with hyperextension of the terminal phalanx. Our end results are evaluated on how much a person can do following operation and properly directed after care as compared with function before accident and injury. The hand primarily enables one to grasp and to hold on to and use an object. We would expect this patient injured in this accident this morning to be able to return to work in the shipping room of the machine shop in five to six months' time. Following his return to work and after he finds out what he will be able to do with this hand as a whole, advice as to further operation would then be given.

Nothing presented in this address is new. It has perhaps taken an unnecessarily long period of time to describe details in the management of this problem. Painstaking attention to all of these details herein noted will aid in wound healing and restoration of function.

One might wonder how this accident could have happened as stated without injury to other structures. However, for the purposes of description no other structures were found injured than noted above. It is well recognized that more than one operative procedure is frequently found necessary in the management of colon, thoracic, urological and other problems. It is also recognized or should be that more than one operation may be necessary in the safe management of a seriously injured hand. In our work in hand surgery we have been considerably aided by the writings of others. Much can be learned from the written experiences of others. More can be learned by watching others at work and by talking with them; and learning from them the real end results of procedures they consider worthwhile.

A new index volume of "Surgery, Gynecology and Obstetrics" will be obtainable within a few weeks. Every surgeon will probably find this volume a necessity. It should be in the library of every hospital where interns and residents are trained. I am informed there is hardly a branch of hand surgery which is not covered by articles listed in this index.

At the Carney Hospital in Boston, as part of the educational program for interns and residents, we refer frequently to the teachings and follow as far as we can the excellent procedures carried out by Koch, Mason, and Allen of Chicago in the management of hand injuries.

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PNEUMONIA NOT RESPONDING TO PENICILLIN

MORGAN CUTTS, M.D.

The Author. *Morgan Cutts, M.D., of Providence. Visiting Physician, Rhode Island Hospital.*

THE THERAPY of pneumonia with penicillin has been so successful and is now so generally employed that it seems unnatural whenever a patient with pneumonia does not improve with this treatment.[1] Occasional failures however still occur. The present investigation is an attempt to discover, if possible, in what way these cases differ from the great majority.

During a two-year period, from November 1, 1945 to November 1, 1947, there were at the Rhode Island Hospital 811 autopsies, and of these 41 had a primary diagnosis of pneumonia at the time of death. From this number were eliminated those dying shortly after admission or otherwise inadequately treated, those clinically diagnosed as primary atypical (virus) pneumonia, those occurring in infants and children under 12, and those with some complication such as cardiac failure or empyema recognized during life which might be expected to render penicillin treatment ineffective. There remained only seven cases that represented instances of pneumonia in adults in whom failure of penicillin therapy was unexplained clinically and in whom autopsies were obtained. A brief analysis of these seven cases follows.

B. K. (#412529) — This 67-year-old man had clinical and X-ray evidence of pneumonia in both lower lobes. White blood count was 34,000 with 90% polymorphonuclears. Pneumococci were typed in the sputum. His temperature promptly fell to normal with penicillin, but the white blood count remained elevated. He failed to improve clinically and died on his twentieth hospital day. Blood urea nitrogen rose from 80 to 100 during his illness.

At autopsy a right-sided empyema and lung abscesses in the right lower lobe were found which had been unsuspected during life. The microscopic sections showed in addition, organizing pneumonia in both lower lobes. Polycystic kidneys accounted for the high blood urea nitrogen.

G. C. (#404905) — This was an 80-year-old man in whom no adequate history could be obtained. X-ray of his chest showed no definite pathology and the diagnosis of pneumonia rested chiefly on the finding of rales throughout both lung fields. No pneumococci was obtained from the sputum and blood culture was sterile. He also had arteriosclerotic heart disease and auricular fibrillation. White blood count was 15,000 with 63% polymorphonuclears. His temperature varied between 100 and 104 uninfluenced by penicillin, and he died on the ninth hospital day.

Autopsy confirmed the diagnosis of bronchopneumonia which in microscopic sections resembled the ordinary type of bacterial pneumonia. No further information was gained as to the exact nature of the infecting organism nor of the reason for failure of penicillin treatments.

A. J. (#414654)—This 73-year-old man could give no adequate history. There were signs and x-ray evidence of patchy bronchopneumonia at both lung bases, and one x-ray showed slight pleural effusion on both sides. White blood counts was 6,000 with 90% polymorphonuclears. Blood culture was sterile. One sputum showed no acid fast organisms. He ran a high irregular fever (to 104°) uninfluenced by penicillin and died on the fourteenth hospital day.

Autopsy showed multiple caseous areas in the lungs and lymph nodes suggestive of tuberculosis, and the microscopic sections showed a picture characteristic of tuberculous pneumonia.

A. H. (#417155)—This 31-year-old woman who had previously been in good health developed a fulminating illness diagnosed as lobar pneumonia three days before admission. There were physical signs and x-ray evidence of patchy consolidation in both lower lobes and less so in the upper lobes as well. Pneumococci were typed in the sputum. Blood culture was sterile. White blood count was 15,000 with 84% polymorphonuclears. She ran a high irregular fever from 101 to 104°, uninfluenced by penicillin and died after four days in the hospital.

Autopsy showed a peculiar type of pneumonia characterized chiefly by changes in the interstitial tissues. The alveolar septa were much thickened and contained many mononuclear cells. The alveoli contained in places a serous fluid and were lined with hyaline pink-staining membranes. The epithelium of the smaller bronchi had been desquamated and the lumen contained a polymorphonuclear

continued on next page

exudate. About the smaller bronchi the interstitial tissues were densely packed with mononuclear cells. This picture is compatible with the so-called primary atypical pneumonia and not with the ordinary pneumococcic penumonia. (See Plate 1)

R. G. (#107041)—This 34-year-old man, previously in good health, entered the hospital on the third day of an illness diagnosed as lobar pneumonia. He was stuporous on admission, temperature was 103+, white blood count 17,000 with 92% polymorphonuclears. X-ray was suggestive of pulmonary edema or bronchopneumonia, more on the right side. One blood culture showed streptococcus viridans. Penicillin was completely ineffective, fever continued and he died on his third hospital day.

Autopsy showed diffuse pneumonia of all lobes which in microscopic sections proved to be characteristic of an acute interstitial pneumonia similar to that described in the previous case. There were also some areas showing a polymorphonuclear exudate in the alveoli.

P. C. (#415560)—This 60-year-old man had severe lobar pneumonia involving the entire right lung and a positive blood culture (pneumococcus, Mixture A). White blood count was 32,000 with 93% polymorphonuclears. He seemed to improve temporarily with penicillin and his temperature dropped from 103.6° to about 101°. On the eighth day, however, his temperature rose again and there was evidence of extension of his pneumonia to the other side. Coincidentally with this, hemolytic staphylococcus aureus was found as the predominating organism in his sputum. He died on his nineteenth hospital day.

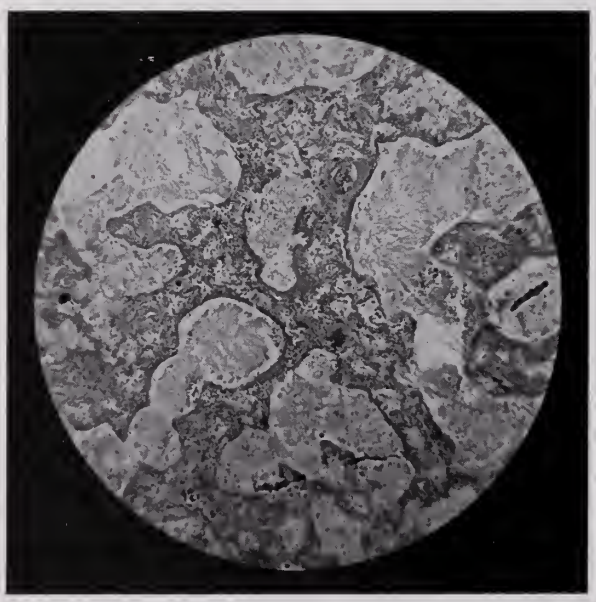


PLATE 1—The alveolar septa are wide due to edema and a cellular exudate. The alveolar spaces are filled with a grandular precipitate, and are lined by a hyaline membrane. (approx. x100)

Autopsy showed widespread pneumonia, resembling microscopically the ordinary bacterial type, and in addition a purulent pericarditis. The post-mortem bacteriology was inconclusive, for though staphylococcus aureus was found on culture of the lung, no organisms were seen in direct smear, and bacterial stains of sections showed only occasional gram positive cocci in pairs. Evidently the unsuspected pericarditis was partly responsible for failure of treatment, whether in addition, a penicillin resistant organism was involved cannot be determined.

A. S. (#416006)—This 65-year-old man entered the hospital after a four days' illness characterized by cough and fever. There were signs of pneumonia over the left lower lobe, and x-ray was consistent with this diagnosis. White blood count was 13,000 with 77% polymorphonuclears. His sputum showed no significant organisms, and blood culture was sterile. His temperature dropped with penicillin treatment, but the patient remained stuporous and died on the fifth hospital day.

At autopsy extensive bronchopneumonia of both lower lobes was found. Smears taken from the lung showed rare gram positive cocci and culture showed a hemolytic staphylococcus aureus, coagulase positive, in addition to other organisms. Microscopically small abscesses were found in the areas of bronchopneumonia. Bacterial stains of these sections showed gam positive cocci in small groups and pairs, morphologically staphylococci. This then represents a case of pneumonia caused by a resistant oragnism probably a staphylococcus. (See Plates 2 and 3)

DISCUSSION: of the seven cases some explanation for their lack of improvement with penicillin was found in six at post mortem. In one empyema and lung abscess, and in another a purulent pericarditis represent complications which are known to be unaffected by intramuscular penicillin. In the case of the pericarditis, there may have been an added factor, perhaps a resistant organism, for there was only a small amount of pericardial fluid (150 cc.), no pericardial adhesions, and the microscopic slides showed a rather recent superficial pericarditis, hardly enough by itself, to account for the patient's downhill course and death. The case of tuberculosis is a useful reminder that one cannot dismiss this as a possibility because of one negative sputum. It is also interesting to note that the lowest white blood count in the group occurred in this case.

The two cases showing the acute interstitial pneumonia are quite similar is many respects. In both the disease was fulminating, death occurring in seven or eight days. Both patients were relatively young, 31 and 34 years. Both had leukocytosis of



PLATE 2—A bronchiole is shown with partially desquamated epithelial lining. Adjacent alveoli are filled with a polymorphonuclear exudate. (approx. x100)

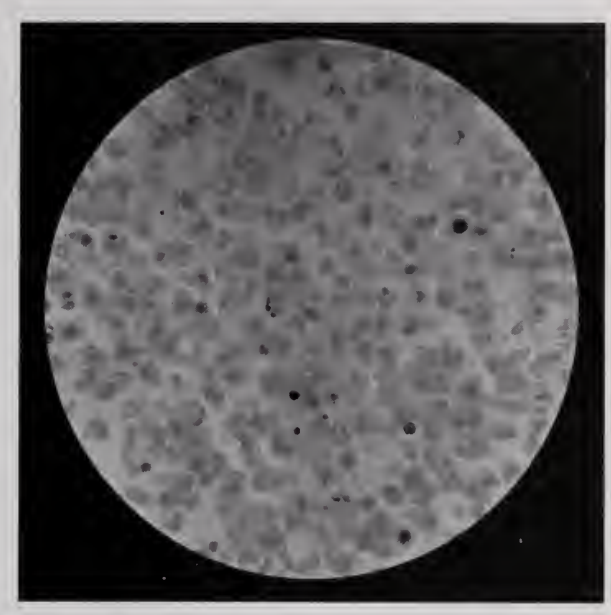


PLATE 3—Gram Stain. In the center of the field are intracellular cocci. (approx. x950)

moderate degree only. The diagnosis was confused rather than clarified by the bacteriological studies, as a pneumococcus was found in the sputum of one and streptococcus viridans in the blood of the other. Both cases show in microscopic sections an acute interstitial pneumonia of the type described in fatal cases of primary atypical (virus) pneumonia.[2,3,4] The first (A. H.) shows nothing else; the other (R. G.) shows also some areas resembling bacterial pneumonia. This association of secondary bacterial invasion is often noted, particularly in the cases who survive longer.

Finally there is one case in which there is good evidence that a staphylococcus aureus was the causative agent. All the post mortem bacteriology, the bacterial stains of the microscopic sections, and the type of pneumonia with polymorphonuclear exudate and small scattered abscesses are consistent with this diagnosis. It is known that staphylococci are less susceptible to penicillin than pneumococci and that some are for all practical purposes completely resistant, either because of the production of penicillinase or through the development of a new strain by mutation.[5] It seems probable that the presence of such a resistant strain is the explanation of the failure of penicillin treatment in this case.

SUMMARY AND CONCLUSIONS: A group of seven cases of pneumonia in whom failure of penicillin therapy was unexplained clinically, were analyzed from the point of view of their post-mortem findings. Partial or complete explanations for this failure of therapy are pointed out in six cases.

The author is indebted to Dr. Robert Williams, Assistant Pathologist, Rhode Island Hospital, for his advice and for the descriptions of the photomicrographs.

[1] Conquest of Pneumonia. Statistical Bulletin Metrop. Life Ins. Co. No. 10 *26* 8-10 Oct. 1945.

[2] Golden, Alfred: Pathologic Anatomy of "Atypical Pneumonia Etiology Undetermined," Acute Interstitial Pneumonitis—Arch. Path *38*-187-202, Oct. 1944.

[3] Kneeland, Yale Jr. and Smetana, Hans F. Current Bronchopneumonia of Unusual Character and Undetermined Etiology. Bull. Johns Hopkins Hosp. *67* 229-267, Oct. 1940.

[4] Parker, F. Jr., Jolliffe, L. S., Barnes, M. W., and Finland, M. Pathologic Findings in Lungs of 5 Cases from which influenza virus was isolated, Am. J. Pathology *22* 797-819, July, 1946.

[5] Spink, Wesley W.. and Ferris, Viola. Penicillin-Resistant Staphylococci Journal of Clin. Investigation, *26* 379-393, May, 1947.

NEXT MEETING OF THE PROVIDENCE MEDICAL ASSOCIATION

MONDAY, NOVEMBER 1.

The RHODE ISLAND MEDICAL JOURNAL

Owned and Published Monthly by the Rhode Island Medical Society,
106 Francis Street, Providence, Rhode Island

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THE NATIONAL MENTAL HEALTH ACT

We are all fairly familiar with the magnitude of the problem of mental illness in this country, and with the great economic loss resulting from such illness. It costs the country approximately a billion dollars a year—twenty-five million annually for state mental hospitals, one hundred million dollars for veterans administration hospitals, and the balance in the reduced earning power of those persons under treatment.

Under the National Mental Health Act the U. S. Public Health Service was authorized to spend, in the first year, four and a half million dollars to improve the mental health of the people. In July, 1947, when funds were appropriated, the program started. It has three major parts: (1) More mental health clinics and other preventive services will be established. (2) Training in psychiatry will be extended. There is need for four times as many trained psychiatrists as are now available to extend the mental health clinics and to conduct research proposed under the Act. It is estimated that $1,100,000 should go to fifty-one universities and hospitals, not only to train more psychiatrists, clinical psychologists, psychiatric nurses and social workers, but also to teach medical students the fundamentals of psychiatry. (3) Research in the field of mental health will be expanded. At the present time only one dollar is spent on mental health research for every one hundred dollars spent on hospitalizing the mentally ill.

There are many gaps in the scientific knowledge of mental illness. Under this national Act it is planned to establish a National Mental Health Institute as part of the National Health Institute being built at Bethesda, Maryland. In administering the Act the United States Public Health Service is advised by a group of psychiatrists, psychologists, social workers and nurses. This advisory group comprises outstanding leaders in the profession who will pass upon all requests for grants-in-aid from the states, for universities, from training centers, and from research workers.

The 80th Congress did not grant the full appropriation requested by the Public Health Service for the extension of this work. Only $300,000 more was voted in 1948 than the previous year. Thus many worthwhile requests for aid from clinics and teaching centers could not be granted.

To make further advances in the prevention and the cure of mental illness many more psychiatrists and other workers must be trained—literally thousands of them—or else there can be little extension of training facilities; and without trained workers very little development of treatment in

out-patient clinics or in the mental hospitals can be expected. The Rhode Island state department of social welfare has applied for a grant, which has been approved, for the extension of treatment facilities for children, and at the present time trained personnel for a new clinic here is being sought.

Every member of the profession knowing the needs in this field should do everything in his power to further progressive and constructive programs in this phase of public health work.



JOHN E. RUISI, M.D.
1892 — 1948

DR. JOHN E. RUISI, F.A.C.S., prominent surgeon, and a civic leader in Westerly for many years, died on May 27, at the age of 56.

A resident of Westerly since 1906, Dr. Ruisi graduated from the high school there prior to his matriculation at Tufts Medical School. He was graduated a doctor of medicine in 1917 and then interned at the Carney hospital in Boston, and later at the Metropolitan hospital in New York City.

During World War I he served 14 months with the medical corps of the American Expeditionary Forces, holding the rank of Captain. He was discharged with the commission of Major, a rank he subsequently held in the Medical Reserve Corps.

He was senior surgeon at Westerly hospital, and a consulting surgeon on the staff of St. Joseph's hospital and Roger Williams hospital, in Providence, and the South County hospital in Wakefield.

Dr. Ruisi was president of the Dante Prize Society which annually awards scholarship prizes to outstanding students in the Italian classes at Westerly high school. He was a member of the Westerly Cooperative Concert Group, and Narragansett Council, Knights of Columbus.

He was also a charter member of the Westerly Lions Club, and a leader in youth movements, especially the Boy Scouts by whom he was presented a bronze statuette in 1947 for "unselfish and outstanding service to the Boy Scouts of the Quequatuck District."

Besides his wife, Renata Flandina Ruisi, his survivors are two sons, Joseph and Edward Anthony, a daughter, Liboria Renata, and two brothers, Leo M. and Anthony R. Ruisi.

If you are not listed correctly in the Annual Roster (see page 620) notify the Executive Office immediately.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACT OF CONGRESS OF AUGUST 24, 1912, AS AMENDED BY THE ACTS OF MARCH 3, 1933, AND JULY 2, 1946

of *Rhode Island Medical Journal*, published monthly at Providence, Rhode Island, for October, 1948.

State of Rhode Island } ss.
County of Providence }

Before me, a Notary Public in and for the State and county aforesaid, personally appeared John E. Donley, M.D., who, having been duly sworn according to law, deposes and says that he is the Associate Editor of the *Rhode Island Medical Journal* and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily, weekly, semiweekly or triweekly newspaper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, as amended by the Acts of March 3, 1933 and July 2, 1946 (section 537, Postal Laws and Regulations), printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are: Publisher, Rhode Island Medical Society, 106 Francis Street, Providence 3, R. I.; Editor, Peter Pineo Chase, M.D., 106 Francis Street, Providence 3, R. I.; Managing Editor, John E. Farrell, 106 Francis Street, Providence 3, R. I.; Associate Editor, John E. Donley, M.D., 106 Francis Street, Providence 3, R. I.
3, R. I.

2. That the owner is Rhode Island Medical Society, 106 Francis Street.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock, bonds, or other securities than as so stated by him.

JOHN E. DONLEY, M.D., *Associate Editor*

Sworn to and subscribed before me this 22nd day of September, 1948.

JOHN E. FARRELL

(My commission expires June, 1950

[SEAL]

THE JOHN F. KENNEY ANNUAL CLINIC OF THE MEMORIAL HOSPITAL INTERNES' ALUMNI ASSOCIATION

at The Memorial Hospital, Pawtucket, Rhode Island on
Wednesday, November 10, 1948

MORNING SESSION (9:30 a.m. to 12:55 p.m.) HENRY B. MOOR, M.D., *Chairman*

9:30– 9:35	GREETINGS	J. LINCOLN TURNER, M.D., *President Internes' Alumni Association*
9:40– 9:55	"DOUBLE KIDNEY — REPORT OF TWO CASES"	FREDERICK A. WEBSTER, M.D.
	"UNUSUAL COMPLICATION OF URETEROLITHOTOMY"	HARRY M. KECHIJIAN, M.D.
10:00–10:20	"UNUSUAL INJURIES ABOUT THE KNEE JOINT"	JOHN H. GORDON, M.D. G. EDWARD CRANE, M.D.
10:25–10:45	"SPONTANEOUS PNEUMOTHORAX"	JOSEPH N. CORSELLO, M.D.
10:50–11:05	"RUPTURED INTERVERTEBRAL DISCS — DIAGNOSIS AND TREATMENT"	LAURENCE A. SENSEMAN, M.D. *Collaborators:* HANIBAL HAMLIN, M.D. HOWARD UMSTEAD, M.D.
11:10–11:30	"GALL BLADDER DISEASE IN A COMMUNITY HOSPITAL"	ORLAND F. SMITH, M.D.
11:35–11:55	"MALIGNANT LYMPHOMA — PATHOLOGY AND X-RAY THERAPY"	ROBERT J. WILLIAMS, M.D. EMANUEL W. BENJAMIN, M.D.
12:00–12:30	"CONGENITAL ANOMALIES OF NEWBORN"	EARL F. KELLY, M.D. WALTER J. DUFRESNE, M.D. JOSEPH H. DOLL, M.D. HRAD H. ZOLMIAN, M.D.
12:35–12:55	QUESTION AND ANSWER PERIOD	

NOTE: *Written questions will be forwarded to the chair during morning session.*

AFTERNOON SESSION (2:00 to 5:00 p.m.) JACOB GREENSTEIN, M.D., *Chairman*

GREETINGS — JOHN F. KENNEY, M.D., *Honorary President, Internes' Alumni Association*

SUBJECT: THE TREATMENT OF PEPTIC ULCER

CLINICAL PATHOLOGICAL CONFERENCE

Part I

Presiding: CLAUDE FORKNER, M.D., Associate Professor of Clinical Medicine, Cornell University Medical College.
(summary of case to be presented will be distributed)

Part II

"MEDICAL ASPECTS OF TREATMENT OF PEPTIC ULCER"
THOMAS P. ALMY, M.D., James Ewing Associate Professor of Neoplastic Diseases, Cornell University Medical College

"TREATMENT OF PERFORATED PEPTIC ULCER.
TREATMENT OF PEPTIC ULCER WITH OBSTRUCTION."
S. W. MOORE, M.D., Associate Professor of Clinical Surgery, Cornell University Medical College.

"TREATMENT OF BLEEDING ULCER.
SURGICAL MANAGEMENT OF THE ULCER WITH INTRACTABLE PAIN.
VAGOTOMY IN THE SURGICAL TREATMENT OF PEPTIC ULCER."
FRANK GLENN, M.D., Professor of Surgery, Cornell University Medical College.

SUMMATION: DRS. CLAUDE FORKNER and FRANK GLENN



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*Viggiano, F. A.: Dysmenorrhea in Industry—Treatment with a New Antispasmodic, Indust. Med. **15**:632 (Nov.) 1946.

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MEDICAL LIBRARY NOTES

THE LIBRARIAN of the Rhode Island Medical Society announces the recent addition of the following books:

ALLERGY

Warren T. Vaughan—*Practice of Allergy.* Revised by J. Harvey Black. 2nd ed. St. L., 1948.

CANCER

Standards for the Diagnosis and Treatment of Cancer by The Cancer Committee of the Iowa State Medical Society. Iowa City, 1948.

DERMATOLOGY

Francesco Ronchese—*Occupational Marks and other Physical Signs. A Guide to Personal Identification.* N. Y., 1948.

ENDOCRINOLOGY

C. Donnell Turner—*General Endocrinology.* Phil., 1948.

HISTORY OF MEDICINE

Cecilia C. Mettler—*History of Medicine. A Correlative Test, Arranged According to Subjects.* Edited by Fred A. Mettler. Phil., 1947.

OPHTHALMOLOGY

Collected Reprints from the Wilmer Ophthalmological Institute of the Johns Hopkins University and Hospital, Vol. VIII, July 1945 to December 1947. Balt., 1948.

PSYCHIATRY

Sigmund Freud—*The Basic Writing of Sigmund Freud.* Translated and Edited, with an Introduction, by Dr. A. A. Brill. N. Y., 1938.

REHABILITATION

Caroline H. Elledge—*The Rehabilitation of the Patient.* Social Casework in Medicine. Phil., 1948.

WRITING

Morris Fishbein & Jewel F. Whelan—*Medical Writing. The Technic and the Art.* 2nd ed. Phil., 1948.

DIRECTORIES

American College of Surgeons. 1947-1949 Year Book. Chic., 1948.

Polk's Providence City Directory, Vol. CVIII, 1948.

GIFTS

Gifts of books and periodicals were received from Doctors Hammond and Mowry, Mr. Farrell and from the Brown University Library.

PHYSICIAN WANTED

A Rhode Island manufacturing company with a large plantation on the Island of Eleuthera in the Bahamas is seeking a doctor to practice there. The company employs a number of white persons and a much larger number of colored natives, the total being about 200 and their families. In addition there are other settlements on the island that have been served until recently by a doctor who has now returned to England. The company is prepared to pay a retainer over and above the fees which would be collected from the patients, and it believes that any physician desiring to retire to live in a pleasant year-round climate would find Eleuthera most attractive as a place of residence. Any physician interested in this proposition is requested to communicate with the Executive Secretary of the Society.



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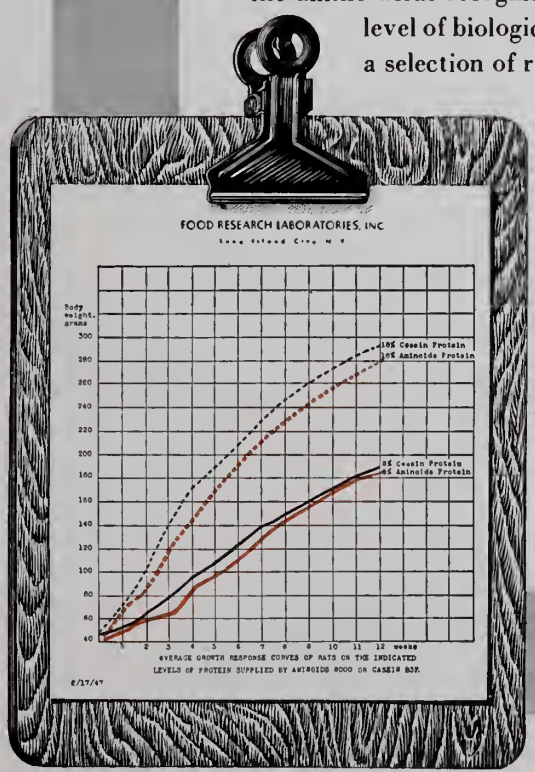
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Lysine — Kossel-Block	2.44	5.8
*Tyrosine — Millon-Lugg	1.76	4.1
Tryptophan — Millon-Lugg	0.56	1.3
Phenylalanine — Kapeller Adler	2.44	5.8
*Cystine — Folin	0.51	1.2
Methionine — Sullivan McCarthy	1.03	2.4
Threonine — Nicolet-Block	1.51	3.6
Leucine — Microbiological	4.33	10.2
Isoleucine — Microbiological	3.26	7.7
Valine — Microbiological	2.86	6.8

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Nicotinic Acid Amide (Nicotinomide)	20.0 mg.

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CANCER CONFERENCE FOR RHODE ISLAND PHYSICIANS

Under Auspices of

Rhode Island Medical Society, Rhode Island State Department of Health, and

Rhode Island Cancer Society

WEDNESDAY, NOVEMBER 17, 1948

Auditorium, Rhode Island Medical Society Library

Presiding: JOSEPH C. O'CONNELL, M.D., *President, Rhode Island Medical Society*

10:30 a.m. THE R. I. STATE HEALTH DEPARTMENT CANCER PROGRAM

Speaker: WALTER BATCHELDER, M.D., *Medical Director, Division of Cancer Control, R. I. State Department of Health.*

11:00 a.m. THE TUMOR CLINIC

JOHN F. KENNEY, M.D., *Former Chief of Medical Service and Director of Laboratories and Tumor Clinic at Memorial Hospital.*

11:30 a.m. THE CANCER DETECTION CLINIC

HERMAN C. PITTS, M.D., *President, Rhode Island Cancer Society.*

12:00 Noon CANCER OF THE BREAST

Speaker: LELAND MCKITTRICK, M.D., *Clinical Professor of Surgery, Harvard. Surgeon, New England Deaconess Hospital.*

12:30 p.m. LUNCHEON (Basement Dining Room)

2:00 p.m. CANCER OF THE COLON AND RECTUM

Speaker: EDWARD J. OTTENHEIMER, M.D., *Surgeon in chief, Windham Community Memorial Hospital.*

2:30 p.m. CANCER OF THE STOMACH

Speaker: GEORGE PACK, M.D., *Attending Surgeon, Memorial Hospital for Cancer and Allied Diseases; (N.Y.); Clinical Professor of Surgery, New York Medical College.*

3:00 p.m. CANCER OF THE SKIN

Speaker: B. EARL CLARKE, M.D., *Pathologist and Director of Laboratories, St. Luke's Hospital, N.Y.C.; Former Director of Tumor Clinic, R. I. Hospital; Member, Board of Directors, American Cancer Society.*

3:30 p.m. CANCER OF THE NOSE AND NASAL SINUSES

Speaker: LEROY A. SCHALL, M.D., *Professor of Laryngology, Harvard Medical School; Chief, Dept., Otolaryngology, Mass. Eye and Ear Infirmary.*

4:00 p.m. CANCER OF THE UTERUS

Speaker: GEORGE W. WATERMAN, M.D., *Chief, Gynecology Staff, Rhode Island Hospital.*

4:30 p.m. ROUND TABLE DISCUSSION. Visiting speakers answering questions.

General discussion from the floor.

5:30-6:30 p.m. SOCIAL HOUR AT THE BILTMORE HOTEL

6:30 p.m. DINNER AT THE BILTMORE HOTEL

Speaker: DR. CLARENCE COOK LITTLE, *Director Roscoe B. Jackson Memorial Laboratory*

TOPIC: "Advances in Cancer Research."

ROSTER OF FELLOWS
of the
RHODE ISLAND MEDICAL SOCIETY
October 20, 1948

Where District Society is not listed after the name the Fellow is a member of the Providence Medical Association.

Telephone numbers have been checked with the latest available directories and every effort has been made to insure accuracy.

Any errors in this listing should be reported immediately to the Executive Office of the Society for correction and special listing in the November issue of the JOURNAL.

A

Abbate, Rocco (*Kent*) 873 Warwick Avenue, Lakewood ..... HO 3323
Abramson, Lewis, 280 Broadway, Newport ..... Newport 5400
Adams, Frank M., 122 Waterman Street, Providence 6 ..... GA 4183
Adelman, Maurice, 209 Angell Street, Providence 6 ..... DE 9129
Adelson, Samuel, (*Newport*) 135 Touro Street, Newport ..... Newport 784-W
Agnelli, Freeman B., (*Washington*) 25 Elm Street, Westerly ..... Westerly 2507
Alexander, George H., Butler Hospital, Providence 6 ..... GA 3456
Allen, Reginald A., 223 Thayer Street, Providence 6 ..... GA 5552, GA 1600
Allin, Francis E., 2247 Mineral Spring Avenue, Centerdale 11 ..... CE 0154-W
Angelone, C. Thomas, 872 Park Avenue, Cranston 10 ..... HO 3900
Angeloni, Tito, 406 Branch Avenue, Providence 4 ..... DE 6676
Appleton, Paul, 35 Taber Avenue, Providence 6 ..... PL 1434
Archetto, Angelo, 964 Cranston Street, Providence 9 ..... WE 3739
Arciero, Michael, 225 Admiral Street, Providence 8 ..... GA 7330, GA 1600
Arlen, Richard S., 359 Broad Street, Providence 7 ..... DE 8210
Armington, Herbert H., 789 Broad Street, Providence 7 ..... WI 0940
Ashton, George W., (*Woonsocket*) Harrisville ..... Pascoag 91
Ashworth, Charles J., 184 Angell Street, Providence 6 ..... GA 4370
Astle, Christopher J., 278 Broad Street, Providence 3 ..... GA 3167

B

Badway, Joseph M., 549 Broadway, Providence 9 ..... UN 2400, GA 1600
Baldridge, Robert R., 192 Angell Street, Providence 6 ..... GA 3448
Bandeian, Alice K., (*Pawtucket*) 84 Broad Street, Pawtucket ..... PE 7420
Barnes, Albert E., (*Pawtucket*) 491 Broad Street, Lonsdale ..... PE 5443
Barnes, Alvah H., 451 Plainfield Street, Providence 9 ..... WE 0052
Baronian, Durtad R., 688 Cranston Street, Providence 7 ..... WI 3310
Barr, Kathleen M., 605 Hope Street, Providence 6 ..... GA 4114
Barrett, Harold S., State Department of Public Health, Division Tuberculosis Cont., State Office Building, Atlanta, Georgia
Barrett, John T., 15 Everett Avenue, Providence 6 ..... GA 2006
Barry, Ambrose G., (*Pawtucket*) 387 Broadway, Pawtucket ..... PE 4661
Bartley, James H., Jr., 7 Benefit Street, Providence 3 ..... DE 6350
Batchelder, Philip, 129 Waterman Street, Providence 6 ..... GA 2166
Batchelder, Walter E., R. F. D. No. 2, North Scituate ..... Scituate 624
Bates, Reuben C., 122 Waterman Street, Providence 6 ..... GA 4233
Baute, Joseph A., (*Kent*) 4547 Post Road, East Greenwich ..... Greenwich 420-W
Beardsley, J. Murray, 82 Waterman Street, Providence 6 ..... UN 1880
Beaudin, Briand N., (*Kent*) St. Vincent's Hospital, New York 11, New York
Beaudoin, Louis I., (*Pawtucket*) 710-a Main Street, Pawtucket ..... BL 2019
Beaudreault, Elphege A., (*Woonsocket*) 441 South Main Street, Woonsocket ..... Woonsocket 5605
Beck, Irving A., 355 Thayer Street, Providence 6 ..... UN 1452
Beckett, Francis H., 189 Waterman Street, Providence 6 ..... GA 3342
Behrendt, Vera M., State Hospital, Howard ..... HO 3700
Bell, Duncan W. J., 211 Angell Street, Providence 6 ..... DE 0159
Bellano, George W., 315 Plainfield Street, Providence 9 ..... WE 4910
Bellino, Antonio, 341 Broadway, Providence 9 ..... PL 2224
Belliotti, Joseph L., 331 Broadway, Providence 9 ..... GA 0582
Benjamin, Emanuel W., 105 Waterman Street, Providence 6 ..... DE 5656

Bernardo, John R., (*Bristol*) 342 High Street, Bristol ..... Bristol 319
Bernasconi, Ezio J., 726 Broad Street, Providence 7 ..... WI 3212
Bernstein, Perry, 140 Orms Street, Providence 8 ..... DE 5115
Berrillo, Anacleto, 401 Broadway, Providence 9 ..... UN 6611
Bertone, Virgilio M., (*Woonsocket*) 21 Hamlet Avenue, Woonsocket ..... Woonosocket 2560
Bestoso, Robert L., (*Newport*) 64 Touro Street, Newport ..... Newport 3036
Bird, Clarence E., 182 Angell Street, Providence 6 ..... GA 6363, GA 1600
Bishop, E. Wade, 182 Waterman Street, Providence 6 ..... GA 2475, GA 1600
Black, Edward J., 169 Angell Street, Providence 6 ..... DE 6059
Blanchard, Howard E., 59 Elmwood Avenue, Providence 7 ..... GA 2622
Blount, Samuel G., 207 Admiral Street, Providence 8 ..... DE 5436
Bolotow, Nathan A., 126 Waterman Street, Providence 6 ..... GA 5387, PL 4987
Bolster, John A., 243 Elmwood Avenue, Providence 7 ..... DE 6270, GA 3332
Botvin, Morris, 155 Angell Street, Providence 6 ..... UN 1210, GA 1600
Boucher, Paul E., (*Woonsocket*) 55 Hamlet Avenue, Woonsocket ..... Woonsocket 67-W
Boucher, Reginald H., (*Pawtucket*) 704-A Main Street, Pawtucket ..... PE 5384
Bourn, Lucy E., 381 Angell Street, Providence 6 ..... DE 1694
Bowen, Earl A., 669 Park Avenue, Cranston 10 ..... HO 4130, GA 1600
Bowles, George E., 155 Thayer Street, Providence 6 ..... DE 1898, GA 1600
Boyd, James F., 195 Angell Street, Providence 6 ..... GA 1589, GA 1600
Brackett, Edward S., 167 Angell Street, Providence 6 ..... GA 6431
Bradley, Charles, University of Oregon, Portland, Oregon
Bradshaw, Arthur B., 49 Beacon Avenue, Providence 3 ..... GA 3852
Bray, Russell S., 454 Angell Street, Providence 6 ..... PL 2440
Brennen, Earle H., 58 John Street, East Providence 14 ..... EA 0942
Breslin, Robert H., 1494 Broad Street, Providence 5 ..... HO 3113
Brochu, Charles E., (*Woonsocket*) 38 Hamlet Avenue, Woonsocket ..... Woonsocket 7202
Brothers, John H., 637 Smith Street, Providence 8 ..... DE 4180
Brown, Abe A., 18963 Wisconsin, Detroit 21, Michigan
Brownell, Henry W., (*Newport*) 10 Bull Street, Newport ..... Newport 512-W
Bryan, Charles E., 425 Willett Aveue, Riverside 15 ..... EA 0961-W
Bruno, Paul C., (*Bristol*) 51 Church Street, Bristol ..... Bristol 514
Buffum, William P., Jr., 122 Waterman Street, Providence 6 ..... GA 3446, GA 1600
Burgess, Alex M., 454 Angell Street, Providence ..... PL 2440
Burgess, Alexander M., Jr., 454 Angell Street, Providence 6 ..... PL 2440
Burke, Edward F., 410 Broadwav, Providence 9 ..... UN 5504, PL 3959
Burling, Temple, R.F.D. No. 1, North Scituate ..... Scituate 4240
Burns, Francis L., 382 Broad Street, Providence 7 ..... DE 1164
Burns, Frederic J., 5 Hillside Avenue, Providence 6 ..... PE 6158-W
Burns, Louis E., (*Newport*) 24 Bull Street, Newport ..... Newport 39
Burrows, Ernest A., 116 Waterman Street, Providence 6 ..... GA 3636
Burton, Kenneth G., 124 Waterman Street, Providence 6 ..... GA 0473, GA 1600
Butler, William J., 199 Angell Street, Providence 6 ..... DE 0294

C

Caldarone, Alfred A., 104 Almy Street, Providence 9 ..... UN 4482
Calder, Harold G., 224 Thayer Street, Providence 6 ..... GA 1947, GA 1600
Calise, Domenico, 441 Broadway, Providence 9 ..... UN 5529
Callahan, James C., (*Newport*) 10 Bull Street, Newport ..... Newport 171
Cameron, Edward S., 82 Waterman Street, Providence 6 ..... GA 1989, GA 1600
Campbell, Walter E., 224 Thayer Street, Providence 6 ..... GA 2324
Capalbo, Sylvester A., (*Washington*) 75 Woodruff Avenue, Wakefield ..... Narr. 414
Capobianco, Giovanni, 536 Admiral Street, Providence 8 ..... GA 5819
Capwell, Remington P., 32 Reservoir Avenue, Providence 7 ..... WI 2255
Cardi, Alphonse R., 1303 Cranston Street, Cranston 9 ..... WE 1836
Carney, Wilfred I., 185 Angell Street, Providence ..... JA 5541
Cardillo, Edward, R. I. Hospital, Providence ..... DE 4300
Carroll, Robert E., 295 Angell Street, Providence 6 ..... GA 7377
Case, Jarvis D., 223 Thayer Street, Providence 6 ..... GA 3040
Castronovo, Joseph, 555 Broadway, Providence 9 ..... UN 6363
Cath, Stanley H., 1st Lt. M.C., Mental Hygiene Consultation Service, Fort Dix, New Jersey
Catullo, Emilie A., 162 Academy Avenue, Providence 8 ..... WE 6858, GA 1600
Celestino, Pasquale J., (*Washington*) Main Street, Hope Valley ..... Hope Valley 154
Cella, Louis J., 514 Broadway, Providence 9 ..... UN 3535
Ceppi, Charles B., (*Newport*) 68 Narragansett Avenue, Jamestown ..... Jamestown 8
Cerrito, Louis C., (*Washington*) 22 Elm Street, Westerly ..... Westerly 4232

continued on next page

ROSTER OF FELLOWS, 1948

continued from page 621

Chace, Robert R., 20 Ridge Road, Bronxville, N. Y.
Chafee, Francis H., 454 Angell Street, Providence 6 ..... PL 2440, GA 1600
Chapas, Benedict, 341 Smith Street, Providence 8 ..... DE 2925
Chapian, Mihran A., 173 Waterman Street, Providence 6 ..... GA 0913, GA 1600
Chapman, James G., (*Pawtucket*) 1189 Smithfield Avenue, Saylesville ..... PE 7340
Charon, Ernest A., 105 Coyle Avenue, Pawtucket ..... BL 3164
Charon, George E., 924 Atwells Avenue, Providence 9 ..... WE 1160
Chase, Peter P., 122 Waterman Street, Providence 6 ..... GA 5023
Chaset, Nathan, 105 Keene Street, Providence 6 ..... UN 8979, GA 1600
Chesebro, Edmund D., 2 Hawthorne Street, Providence 7 ..... WI 1223
Cianci, Vincent A., 54 Pocasset Avenue, Providence 9 ..... WE 4639
Ciarla, Philomen P., (*Newport*) 105 Pelham Street, Newport ..... Newport 531
Cicma, Haralambie G., 63 Angell Street, Providence 6 ..... GA 8485
Clark, Samuel D., (*Bristol*) 366 Hope Street, Bristol ..... Bristol 3-W
Clarke, B. Earl, Rhode Island Hospital, Providence ..... DE 4300
Clarke, Elisha D., 109 North Richhill Street, Waynesburg, Pennsylvania
Clarke, Elliott M., (*Pawtucket*) 288 Central Street, Central Falls ..... PE 6760-W
Clune, James P., 156 Auburn Street, Cranston 10 ..... HO 1900
Cohen, Earle F., 176 Waterman Street, Providence ..... JA 5100
Cohen, Leo, 164 Prairie Avenue, Providence 5 ..... GA 3326
Cohen, Paul, (*Woonsocket*) 99 Main Street, Woonsocket ..... Woonsocket 6117-R
Cohen, William B., 105 Waterman Street, Providence 6 ..... GA 0843
Colagiovanni, Marco, 288 Broadway, Providence 3 ..... GA 5894, WE 1561
Collom, Harold L., (*Kent*) 3235 Post Road, Apponaug ..... Hillsgrove 1214
Conde, George F., 137 Academy Avenue, Providence 8 ..... WE 6231
Congdon, Palmer, 211 Angell Street, Providence 6 ..... UN 0117
Conlon, Leo V., (*Woonsocket*) 113 Main Street, Woonsocket ..... Woonsocket 2482-W
Conrad, E. Victor, 203 Angell Street, Providence 6 ..... GA 4624
Conte, Alfred C., 540 Charles Street, Providence 4 ..... GA 8895
Cook, Paul C., 1451 Broad Street, Providence 5 ..... WI 4412
Cooke, Charles O., 171 Angell Street, Providence 6 ..... DE 2145
Corbett, Francis A., (*Newport*) 24 Spring Street, Newport ..... Newport 737
Corcione, Mary B., 409 Broadway, Providence 9 ..... UN 3154
Cormier, Evariste A., (*Pawtucket*) 1258 Newport Avenue, Pawtucket ..... PE 0234
Corrigan, Francis V., 613 Angell Street, Providence 6 ..... GA 1347
Corsello, Joseph N., (*Providence*) 235 Broadway, Providence 3 ..... WE 3051-GA 4333
Corvese, Anthony, 243 Broadway, Providence 3 ..... DE 7677
Cox, James H., 141 Waterman Street, Providence 6 ..... GA 6336
Crane, G. Edward, 223 Thayer Street, Providence 6 ..... GA 5324
Crank, Rawser P., 794 Park Avenue, Cranston 10 ..... WI 1614
Cranor, John R., Jr., Belleville, Pa.
Crepeau, George A., (*Woonsocket*) 34 Hamlet Avenue, Woonsocket ..... Woonsocket 3102-W
Crowley, James H., 1656 Broad Street, Edgewood 5 ..... HO 6833, GA 1600
Cuddy, Arthur B., 512 Pontiac Avenue, Cranston 10 ..... WI 5249, GA 1600
Cummings, Frank A., 169 Angell Street, Providence 6 ..... DE 6622
Curran, Edmund B., Georgetown University Hospital, Washington, D. C.
Curren, L. Addison, 789 Park Avenue, Cranston ..... WI 1568
Cutts, Frank B., 124 Waterman Street, Providence 6 ..... GA 3111, GA 1600
Cutts, Katherine K., 9 Irving Avenue, Providence 6 ..... PL 4772
Cutts, Morgan, 155 Thayer Street, Providence 6 ..... DE 3427

D

Damarjian, Edward, 972 Broad Street, Providence 5 ..... WI 8806
D'Angelo, Antonio F., 99 State Street, Bristol ..... Bristol 761
Darrah, Harry E., 42 Woodbury Street, Providence 6 ..... DE 1035
Dashef, Oscar Z., (*Woonsocket*) 202 Stadium Building, Woonsocket ..... Woonsocket 6011-W
Davies, Stanley D., (*Kent*) 1225 Main Street, West Warwick ..... Valley 0961
Davis, George W., 1732 Broad Street, Edgewood 5 ..... WI 2433, GA 1600
Davis, William P., 182 Waterman Street, Providence 6 ..... DE 1536, GA 1600
Deery, James P., 331 State Office Building, Providence 2 ..... JA 7100
DeFusco, Bruno G., 369 Broadway, Providence 9 ..... UN 4509, DE 8311
DeLuca, Joseph, 158 Governor Street, Providence 6 ..... PL 2243
Denhoff, Eric, 187 Waterman Street, Providence 6 ..... GA 1837
DeNyse, Donald L., 922 Park Avenue, Cranston 10 ..... WI 2266, GA 3333
DeStefani, Carlo J., (*Woonsocket*) 689 Wood Street, Woonsocket ..... Woonsocket 3566
Devere, Frederick H., 677 Park Avenue, Auburn 10 ..... HO 0242

DeWolf, Halsey, 305 Brook Street, Providence 6 ..... GA 5484
Dileone, Ralph, 223 Broadway, Providence 3 ..... GA 3468
Dillon, John A., 255 Hope Street, Providence 6 ..... UN 2323
DiMaio, Michael, 415 Angell Street, Providence ..... JA 6682
Dimmitt, Frank W., 78 Waterman Street, Providence 6 ..... GA 2886, GA 1600
DiPippo, Palmino, 1536 Westminster Street, Providence 9 ..... WE 1567
Dolan, Thomas J., 60 South Angell Street, Providence 6 ..... GA 5610
Donley, John E., 222 Broadway, Providence 3 ..... UN 1313
Donnelly, John J., 603 Broad Street, Providence 7 ..... PL 2310, GA 3333
Dotterer, Charles S., (*Newport*) 193 Waterman Street, Providence 6 ..... DE 8433
Dotterer, Charles S., (*Newport*) 11 Redwood Street, Newport, 193 Waterman Street, Providence 6 ..... Newport 2950, DE 8433
Dougherty, Edward F., 6374 7th Ave. N., St. Petersburg, Florida
Dowling, Joseph L., 57 Jackson Street, Providence 3 ..... GA 3552
Dowling, Richard H., (*Woonsocket*) 128 Main Street, Woonsocket ..... Woonsocket 167-W
Drew, Robert W., (*Bristol*) 391 Main Street, Warren ..... Warren 1490
Duckworth, Milton, (*Washington*) Carolina ..... Carolina 17R2
Dufresne, Walter J., (*Pawtucket*) 168 West Avenue, Pawtucket ..... PE 3640
Dugas, Leo, (*Woonsocket*) Slatersville ..... Woonsocket 122-W
D'Ugo, William P., 282 Broadway, Providence 3 ..... GA 0151
Dunbar, Charles W., 10 Appian Way, W. Barrington 14 ..... Warren 1106
Duquette, Leo H., (*Kent*) 1044 Main Street, West Warwick ..... Valley 0774
Durkin, Patrick A., (*Pawtucket*) 459 Central Avenue, Pawtucket ..... PE 1457-W
Durkin, Walter R., 111 Waterman Street, Providence 3 ..... DE 2224, WI 3595
Dustin, Cecil C., 199 Thayer Street, Providence 6 ..... DE 1090
Dwyer, George J., 796 Atwells Avenue, Providence 9 ..... WE 3831
Dziob, John S., 148 Blackstone Blvd., Providence 6 ..... DE 7360

E

Earley, Charles P., 388 Prairie Avenue, Providence 5 ..... HO 9285
Eckert, George A., (*Newport*) 130 Touro Street, Newport ..... Newport 35-W
Eckstein, Adolph W., 76 Waterman Street, Providence 6 ..... GA 0767, GA 1600
Eddy, Augustine W., (*Woonsocket*) 42 Hamlet Avenue, Woonsocket ..... Woonsocket 207-W
Eddy, Jesse P., 3rd, 131 Waterman Street, Providence 6 ..... PL 4044
Egan, Thomas A., 156 Smith Street, Providence 8 ..... DE 9414, GA 1600
Eliot, Alice M. B., Adams Point, Barrington ..... WA 0857
Emidy, H. Lorenzo, (*Woonsocket*) 188 Prospect Street, Woonsocket ..... Woonsocket 92
Erinakes, Peter C. (*Kent*) 1425 Main Street, West Warwick ..... Valley 0896-W

F

Fagan, James H., 230 Thayer Street, Providence 6 ..... GA 7242
Fain, William, 249 Thayer Street, Providence 6 ..... GA 7271, GA 3333
Fallon, James T., Charles V. Chapin Hospital, Providence 8 ..... DE 7400
Famiglietti, Edward V., 77 Brown Street, Providence 6 ..... UN 0023, GA 1600
Farago, Samuel S., (*Washington*) 101 West Broad Street, Westerly ..... Westerly 2432
Farrell, Charles L., (*Pawtucket*) 166 Pawtucket Avenue ..... PE 7101
Farrell, George B., (*Kent*) 1018 Main Street, West Warwick ..... VAlley 0038
Farrell, Irving A., (*Pawtucket*) 428 Broad Street, Central Falls ..... PE 6284-W
Farrell, Robert L., 57 Beacon Avenue, Providence 3 ..... UN 1814
Feifer, Anthony M., 547 Broadway, Providence 9 ..... UN 3915
Feinberg, Banice, 183 Angell Street, Providence 6 ..... UN 2242
Femino, Richard D., 666 Douglas Avenue, Providence 8 ..... UN 1433
Ferguson, Duncan H. C., Jr., (*Pawtuket*) 75 Park Place, Pawtucket ..... PE 7317
Ferguson, John B., 205 Broad Street, Providence 9 ..... GA 2799, GA 1600
Ferrara, Bernardino F., 211 Webster Avenue, Providence 9 ..... WE 1802
Ferrucci, Domenic P., (*Woonsocket*) 80 Hamlet Avenue, Woonsocket ..... Woonsocket 826
Fershtman, Max B., 708 Park Avenue, Cranston 10 ..... WI 4346
Fidanza, Antonio G., 240 Pocasset Avenue, Providence 9 ..... WE 2562
Field, Eugene A., 112 Waterman Street, Providence 6 ..... GA 5016
Fischer, William J. H., Jr., 302 Thayer Street, Providence 6 ..... GA 2676
Fish, David J., 355 Thayer Street, Providence 6 ..... JA 9012
Fish, Vera J. W., State Hospital, Howard ..... HO 3700
Fishbein, Jay N., 221 Angell Street, Providence 6 ..... GA 3452, GA 1600
Fitts, Fernald C., (*Washington*) 881 Lafayette Street, Bridgeport, Conn.
Fitzpatrick, Walter F., Jr., 321 Hope Street, Providence 6 ..... UN 2622
Fletcher, Donald B., (*Newport*) Newport Hospital, Newport ..... Newport 410

continued on next page

ROSTER OF FELLOWS, 1948

continued from page 623

Fletcher, Henry B., 14 South Meadow Lane, Barrington ..... Warren 1472-W
Fletcher, William, 812 Industrial Trust Bldg., Providence ..... GA 9230
Flynn, Joseph C., 559 Cranston Street, Providence 7 ..... WE 2221
Flynn, Thomas S., (*Woonsocket*) 11 Monument Square, Woonsocket ..... Woonsocket 908-W
Fogarty, Thomas E., 224 Thayer Street, Providence 6 ..... GA 0217
Foley, William H., 810 Broad Street, Providence 7 ..... WI 2727
Fontaine, Aurey, *(Woonsocket)* 52 Hamlet Avenue, Woonsocket ..... Woonsocket 246
Forget, Ulysse, (*Bristol*) 600 Main Street, Warren ..... WA 0070
Fortunato, Stephen J., 425 Plainfield Street, Providence 9 ..... WE 0057
Foster, Edward, *(Pawtucket)* 569 Power Road, Pawtucket ..... BL 2070
Fox, A. Henry, 518 Willett Avenue, East Providence ..... EA 3372
Fox, G. Raymond, (*Pawtucket*) 209 Broadway, Pawtucket ..... PE 8621
Fracasse, John, 23 Joslin Street, Providence 9
Franklin, Joseph, 217 Elmwood Avenue, Providence 7 ..... GA 7348
Fratantuono, Frank D., 106 Vinton Street, Providence 9 ..... PL 4493, PL 9601
Freedman, David, 224 Thayer Street, Providence 6 ..... DE 0042
Freedman, Stanley S., 183 Waterman Street, Providence 6 ..... DE 8447
Fruggiero, Enzo, J., 68 Beaufort Street, Providence 8 ..... WE 4536-R
Frumson, Solomon L., *(Woonsocket)* Monument Square, Woonsocket ..... Woonsocket 719-R
Fuhrmann, Louis J., 933 Chalkstone Avenue, Providence 8 ..... PL 4539
Fulton, Frank T., 124 Waterman Street, Providence 6 ..... GA 3111
Fulton, Marshall, 124 Waterman Street, Providence 6 ..... GA 3111

G

Gale, Elmer T., *(Washington)* 5 Robinson Street, Narragansett ..... Narragansett 800-W
Gallagher, Henry J., 386 Smith Street, Providence 8 ..... DE 5967
Gammell, Edwin B., 441 Angell Street, Providence ..... JA 1177
Gannon, Charles H., 23 Holburn Avenue, Cranston ..... WI 1713
Garrison, Norman S., *(Woonsocket)* Box 547, Westerly ..... Watch Hill 52-3
Garside, Francis V., 154 Francis Street, Providence 3 ..... DE 7572, GA 1600
Gaudet, Albert J., *(Pawtucket)* 592 Smithfield Avenue, Pawtucket ..... PE 2383
Gauthier, Henri E., *(Woonsocket)* 34 Hamlet Avenue, Woonsocket ..... Woonsocket 393-325
Gerber, Isaac, 10 Leicester Way, Pawtucket ..... PE 7353
Geremia, Albert E., 172 Pocasset Avenue, Providence 9 ..... WE 8136
Gershman, Isadore, 343 Thayer Street, Providence 6 ..... GA 1551
Giannini, Pio, 446 Broadway, Providence 9 ..... UN 3860
Gibson, J. Merrill, 185 Angell Street, Providence 6 ..... UN 1243
Gilbert, John J., 209 Angell Street, Providence 6 ..... GA 1584
Giles, William P., 480 Lowell Avenue, Newtonville, Mass.
Gillis, Nora P., 189 Governor Street, Providence ..... GA 3215
Giunta, Frank, 403 Montgomery Avenue, Providence ..... HO 6135
Giura, Arcadie, *(Bristol)* 31 Washington Street, Warren ..... Warren 0680
Goldberger, Milton, 729 North 6th Avenue, Tucson, Arizona
Goldowsky, Seebert J., 209 Angell Street, Providence 6 ..... UN 1707
Goldstein, Sidney S., 203 Thayer Street, Providence 6 ..... DE 5666, GA 1600
Golini, Carlotta N., 371 Broadway, Providence 9 ..... UN 6603
Gongaware, Hartford P., *(Washington)* 17 Granite Street, Westerly ..... Westerly 2246
Gordon, John H., *(Pawtucket)* 47 Cottage Street, Pawtucket ..... PE 5280
Gordon, Walter C., 116 Princeton Avenue, Providence 7 ..... JA 4040
Gormly, John A., 187 Academy Avenue, Providence 8 ..... WE 5185
Granata, Tancredi G., 347 Broadway, Providence 9 ..... DE 0281, WE 1671-W
Granger, Eugene N., Pascoag ..... Pascoag 80
Greason, Thomas L., 677 Broad Street, Providence ..... UN 3355
Greenstein, Jacob, 143 Prairie Avenue, Providence 5 ..... GA 1969
Gregory, Kalei K., 211 Angell Street, Providence 6 ..... DE 2459
Grenolds, Walter J., *(Washington)* 9 Elm Street, Westerly ..... Westerly 2772
Grimes, M. Osmond, *(Newport)* 57 Kay Street, Newport ..... Newport 2824
Gross, Carl R., 102 Olney Street, Providence 6 ..... DE 8620
Grossman, Herman P., 211 Angell Street, Providence 6 ..... DE 2433
Grzebein, Stanley T., 681 Smith Street, Providence 8 ..... DE 6334
Grzebien, Thomas W., 187 Academy Avenue, Providence 8 ..... WE 3061, GA 1600

H

Hacking, Raymond F., 105 Waterman Street, Providence 6 ..... GA 1613
Hackman, Edmund T., *(Kent)* 10 Post Road, Warwick ..... WI 2883
Hagenow, LeRoy K., (*Kent*) 3166 Post Road, Apponaug ..... Hillsgrove 1224

continued on page 626

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ROSTER OF FELLOWS, 1948

continued from page 624

Hager, Herbert F., 203 Thayer Street, Providence 6 ..... GA 0581
Hall, Hugh J., 1283 North Main Street, Providence 4 ..... GA 1162, GA 1600
Ham, John C., 124 Waterman Street, Providence 6 ..... GA 3111
Hamilton, James, 349 Hope Street, Providence 6 ..... GA 4646
Hamlin, Hannibal, 4 George Street, Providence 6 ..... UN 2630
Hammond, Roland, 41 Boylston Avenue, Providence 6 ..... PL 5949
Hanley, Francis E., *(Pawtucket)* 336 North Broadway, Providence 16 ..... EA 1236
Hanley, Henry J., (*Pawtucket*) 23 Park Place, Pawtucket ..... PE 5422
Hanna, Louis E., *(Pawtucket)* 164 Central Avenue, Pawtucket ..... PE 9171
Hanson, F. Charles, 162 Angell Street, Providence 6 ..... GA 9234, GA 1600
Happ, Linley C., 170 Waterman Street, Providence 6 ..... GA 6855
Hardiman, James F., 432 Public Street, Providence ..... HO 6500
Hardman, Margaret S., 46 Armington Avenue, Providence 8 ..... WE 1995
Hardy, Arthur E., (*Kent*) 2 Post Road, Pawtuxet ..... HO 9212
Harley, Benjamin F., 154 Angell Street, Providence 6 ..... GA 0532
Harrington, Peter F., 249 Hope Street, Providence 6 ..... DE 2200
Harris, Herbert E., 219 Waterman Street, Providence 6 ..... GA 1721
Harrop, Joseph K., *(Kent)* 1097 Main Street, West Warwick ..... Valley 1233
Harvey, N. Darrell, 112 Waterman Street, Providence 6 ..... GA 6637
Hascall, Theodore C., 44 Lincoln Avenue, Riverside ..... EA 0020
Hathaway, Clifford S., (*Washington*) 38 Lake Street, Wakefield ..... Narragansett 640
Haverly, Richard E., 841 Hope Street, Providence 6 ..... GA 9825
Hawkins, Joseph F., 197 Waterman Street, Providence 6 ..... GA 2552
Hayes, Robert C., (*Pawtucket*) 166 Pawtucket Avenue, Pawtucket ..... PE 7101
Hayes, Walter E., 1103 Cranston Street, Cranston ..... WE 4480
Healey, James P., *(Pawtucket)* 84 Broad Street, Pawtucket ..... BL 1382
Hecker, Harry, *(Pawtucket)* 172 East Avenue, Pawtucket ..... PE 1682
Heffernan, Edward V., 148 Brunswick Avenue, Gardiner, Maine
Hemond, Fernand J., *(Kent)* 12 St. John Street, West Warwick ..... Valley 0019
Hennessey, Kiernan W., *(Pawtucket)* 520 East Avenue, North Providence 11 ..... PE 8032
Henry, Albert C., *(Wshington)* West Main Street, Wickford ..... Wickford 409
Henry, Robert T., *(Pawtucket)* 18 Exchange Street, Pawtucket ..... PE 5184-W
Hill, Prescott T., 225 Broad Street, Providence 3 ..... DE 0191, GA 1600
Hindle, Joseph A., 655 Broad Street, Providence 7 ..... DE 6310
Hindle, William V., 655 Broad Street, Providence 7 ..... DE 6311
Hodgson, William H., 1874 Broad Street, Cranston 5 ..... WI 2522
Hoey, Waldo O., 295 Angell Street, Providence 6 ..... PL 1300
Hogan, John P., 655 Broad Street, Providence 7 ..... UN 9544
Holdsworth, Hubert, (*Bristol*) 366 Hope Street, Bristol ..... Bristol 734
Hollingworth, Arthur, Hope Road ..... Scituate 528
Honan, Frank J., 116 Governor Street, Providence 6 ..... GA 9076
Horan, William A., 319 Broad Street, Provi dence 7 ..... GA 1251
Horvitz, Abraham, 111 Waterman Street, Providence ..... JA 9432
Horwitz, Manuel, 407 Brook Street, Providence 6 ..... GA 5415
Houghton, Montafix W., Congdon Street, Providence 6 ..... DE 4444
Houston, Craig S., 195 Angell Street, Providence 6 ..... GA 6886
Howrie, William C., Jr., 280 Benefit Street, Providence ..... JA 8948
Hubbard, John D., 162 Angell Street, Providence 6 ..... DE 0626
Hudson, Royal C., *(Kent)* 1225 Main Street, West Warwick ..... Valley 0961
Hughes, Stephen F., *(Pawtucket)* 33 Main Street, Pawtucket ..... PE 0460
Hughes, William N., 112 Waterman Street, Providence 6 ..... GA 1431
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Hunt, William W., 93 Warren Avenue ..... EA 0031
Hyer, Harrison F., Box 486, Belchertown, Mass.
Hyer, Oscar H., 115 Governor Street, Providence ..... PL 1331

I

Iavazzo, Anthony A., 227 Laurel Hill Avenue, Providence 9 ..... WE 3850
Indeglia, Pasquale V., 451 Broadway, Providence 9 ..... UN 6070
Israel, Cyril, *(Woonsocket)* 18 Monument Square, Woonsocket ..... Woonsocket 3891-R

J

Jackvony, Albert H., 339 Elmwood Avenue, Providence 7 ..... HO 1141
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continued on page 628





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continued from page 626

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Jeremiah, Bert S., *(Pawtucket)* 614 East Avenue, Pawtucket ..... BL 3216
Johnson, William J., *(Washington)* 26 North Road, Kingston, P. O. Box 43, Narragansett 552-M
Johnston, Joseph C., 369 Broad Street, Providence 7 ..... GA 9885
Jones, Henry A., 506 Pontiac Avenue, Cranston ..... WI 3420
Jones, John P., *(Washington)* 127 Main Street, Wakefield ..... Narragansett 3
Jones, Walter S., 165 Waterman Street, Providence 6 ..... GA 8551
Jones, Harmon P. B., 50 Maude Street, Providence 8 ..... DE 3200
Jordan, William H., 570 Broad Street, Providence 7 ..... DE 0900
Joyce, Henry S., 201 Waterman Avenue, East Providence 14 ..... EA 4123

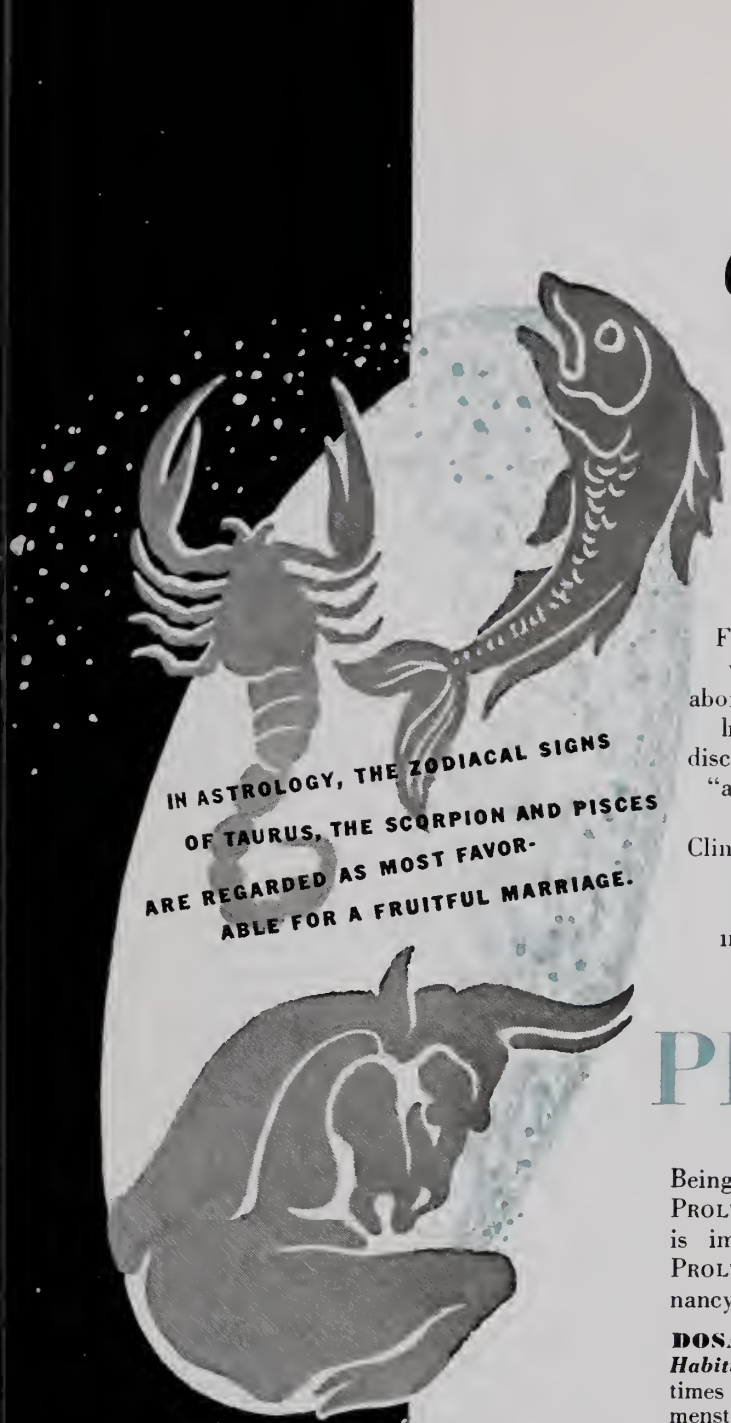
K

Kalcounos, William N., *(Pawtucket)* 101 Broadway, Pawtucket ..... PE 5305-W
Kant, Alfred, Massachusetts Eye and Ear Infirmary, Boston, Massachusetts
Kapnick, Israel, 224 Thayer Street, Providence 6 ..... GA 3143
Kaskiw, Emil A., *(Woonsocket)* 200 Harris Avenue, Woonsocket ..... Woonsocket 6005
Kay, Maurice N., 183 Waterman Street, Providence 6 ..... GA 2230
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Kechijian, Natalie, *(Pawtucket)* 84 Broad Street, Pawtucket ..... PE 7420
Keegan, George A., *(Woonsocket)* 34 Hamlet Avenue, Woonsocket ..... Woonsocket 3400-W
Kelley, Jacob S., 153 Smith Street, Providence 8 ..... DE 6665
Kelly, Earl F. *(Pawtucket)* 21 High Street, Pawtucket ..... PE 0220-W
Kempker, Adele C., State Hospital, Howard ..... HO 4700
Kennedy, John A., *(Woonseocket)* 194 Main Street, Woonsocket ..... Woonsocket 2708 W
Kenney, John F., *(Pawtucket)* 19 Kenilworth Way, Pawtucket ..... PE 0049
Kenney, Stephen A., *(Pawtucket)* 258 Broad Street, Valley Falls ..... PE 4452
Kennon, Charles E. V., 223 Congress Avenue Providence 7 ..... HO 3434
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Kenyon, Frances A., (*Washington*) Woodville Road, Woodville ..... Carolina 18R2
Kenyon, Harold D., *(Washington)* Box 226, Misquamicut Hills, Westerly ..... Watch Hill 7137
Keohane, John T., 586 Broad Street, Providence 3 ..... UN 1221, GA 1600
Kiene, Hugh E., 111 Watermean Street, Providence 6 ..... PL 5759
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King, Arthur W., (*Newport*) Harbor Road, Adamsville ..... Newport 452
King, Francis J., *(Woonsocket)* 189 Harris Avenue, Woonsocket ..... Woonsocket 662
Kingman, Lucius C., 76 Waterman Street, Providence 6 ..... DE 6138, GA 1600
Kirk, George E., 1337 Smith Street, Providence 11 ..... WE 3122
Kiven, Nathan J., 111 Waterman Street, Providence 6 ..... PL 5759, UN 0110, GA 1600
Kostyla, Edward A. (*Kent*) 15 Washington Street, West Warwick ..... Valley 099-W
Koch, Peter, Jr., (*Kent*) 14 Pulaski Street, West Warwick
Kraemer, Richard J., *(Washington)* 586 Broad Street, Providence 7 ..... UN 1232
Kramer, Louis I., 126 Waterman Street, Providence 6 ..... GA 3235
Krolicki, Thaddeus A., (*Pawtucket*) 102 Waterman Street, Providence 6 ..... JA 9090

L

Ladd, Joseph H., *(Washington)* Exeter School, Lafayette ..... Wickford 4
Lagerquist, A. Lloyd, 73 Willett Avenue, Riverside ..... EA 4615
Lalonde, Alphonse J., *(Pawtucket)* 485 Armistice Boulevard, Pawtucket ..... PE 1876
Lalor, Thomas J., Jr., *(Woonsocket)* 285 Main Street, Woonsocket ..... Woonsocket 78-W
Lamb, Francis D., *(Kent)* 11 Harris Avenue, West Warwick ..... VAlley 0107
Lamoureux, Stanislas A., *(Pawtucket)* 208 Broad Street, Pawtucket ..... PE 5164-W
Landsteiner, Ernest K., 4 George Street, Providence 6 ..... UN 2630
Langdon, John, 43 Irving Avenue, Providence 6 ..... GA 1016
Laskey, Howard G., *(Washington)* Carolina ..... Carolina 30 Ring 4
Laufer, Maurice W., Emma Pendleton Bradley Home, Providence 15 ..... EA 3400
Laurelli, Edmond C., *(Pawtucket)* 188 Main Street, Pawtucket ..... PE 5451-W
Lawson, Herman A., 454 Angell Street, Providence 6 ..... PL 2440, GA 1600
Lawton, Anne L., State Infirmary, Howard ..... HO 3700
Leech, Clifton B., 82 Waterman Street, Providence 6 ..... GA 5171
Leet, William L., 199 Thayer Street, Providence 6 ..... UN 1158
Lent, James W., *(Newport)* Main Road, Tiverton ..... Tiverton 24
Lenzner, Simon G., 187 Waterman Street, Providence 6 ..... DE 8710
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continued on page 630



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BIBLIOGRAPHY: 1. Frank, R. T.: M. Clin. North America **25**:607, 1941. 2. Kane, H. F.: Am. J. Obst. & Gynec. **32**:110, 1936. 3. Mason, L. W.: Am. J. Obst. & Gynec. **44**:630, 1942. 4. Krohn, L., and Harris, J. M.: Am. J. Obst. & Gynec. **41**:95, 1941. 5. Soule, S. D.: Am. J. Obst. & Gynec. **42**:1009, 1941.

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continued from page 628

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Lippitt, Louis D., 41 Pocasset Avenue, Providence 9 ..... WE 3551
Lisbon, Wallace, 928 Smith Street, Providence 8 ..... WE 4121
Litchman, David, 102 Waterman Street, Providence 6 ..... UN 1563
Littlefield, Frank B., 199 Thayer Street, Providence 6 ..... UN 1446
Littleton, Thomas R., 261 Rhodes Street, Providence 5 ..... DE 7027
Logler, Frank J., *(Newport)* 42 Kay Street, Newport ..... Newport 2498-W
Londergan, James P., 81 Governor Street, Providence 6 ..... GA 4255
Lord, Robert M., 122 Waterman Street, Providence 6 ..... GA 2163
Lovering, Edwin F., *(Pawtucket)* 209 Broadway, Pawtucket ..... PE 0072-W
Luongo, Fedele U., 508 Charles Street, Providence 4 ..... DE 2867
Lupoli, Alphonse W., *(Kent)* 3291 Post Road, Apponaug ..... Hillsgrove 1600-W
Lury, John J., 1424 Broad Street, Providence 5 ..... HO 3300
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M

MacCardell, Frank C., 193 Waterman Street, Providence 6 ..... DE 8433
MacDonald, William J., 221 Thayer Street, Providence ..... GA 1710
Mack, John A., *(Kent)* 1575 Main Street, West Warwick ..... VAlley 0639
MacLeod, Norman M., 114 Touro Street, Newport ..... Newport 282
Magill, William H., 116 Waterman Street, Providence 6 ..... GA 3539
Mahoney, Andrew W., 1404 Westminster Street, Providence 3 ..... WE 0200
Mahoney, William A., 44 Motague Street, Providence 6 ..... PL 1094
Maiello, Robert, 299 Broadway, Providence 3 ..... GA 3377
Malinou, Nathaniel J., 334 Smith Street, Providence 8 ..... DE 2123
Malone, John M., *(Newport)* 101 Water Street, Portsmouth ..... Portsmouth 47
Mamos, Photius D., 600 Broad Street, Providence 7 ..... GA 2853
Mandell, Israel, 50 Oakland Avenue, Providence 8 ..... GA 2450
Manganaro, Attilio L., *(Washington)* 95 Kingstown Road, Peace Dale ..... Narragansett 94
Manning, Patrick J., *(Washington)* 35 Brown Street, Wickford ..... Wickford 77
Mara, Earl J., *(Pawtucket)* 260 Lonsdale Avenue, Pawtucket ..... PE 0883-W
Margossian, Arshag D., 315 Broad Street, Providence 7 ..... GA 0516
Marks, Herman B., 183 Angell Street, Providence 6 ..... UN 1020, GA 1600
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Marks, Morris, *(Pawtucket)* 838 Newport Avenue, Pawtucket ..... PE 6783-W
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Martin, Arthur E., 101 Waterman Street, Providence 6 ..... GA 9271
Martin, Richard J., Box 9, North Scituate ..... Scituate 347
Martineau, Lawrence A., Rhode Island Hospital, Providence 2 ..... DE 4300
Marzilli, Alexander F., 7 Dexter Street, Providence 9 ..... WE 3366
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Mathews, George S., 114 Brown Street, Providence 6 ..... DE 6742
Mathewson, Earl J., *(Pawtucket)* 20 Park Place, Pawtucket ..... PE 6898
Matteo, Frank I., 463 Broadway, Providence 9 ..... UN 3111
Mattera, Vincent J., 425 Broadway, Providence 9 ..... UN 2526
Maynard, Irene G., *(Kent)* 40 Curson Street, West Warwick ..... VAlley 1305
Maynard, Jean M., *(Kent)* 40 Curson Street, West Warwick ..... VAlley 1305
Mayner, Frank A. *(Newport)* Newport Hospital, Newport ..... Newport 410
McAteer, Raymond F., *(Washington)* 1880 Broad Street, Cranston 5 ..... WI 6565, GA 1600
McCabe, Francis J., 204 Angell Street, Providence 6 ..... PL 3675
McCaffrey, James P., 116 Waterman Street, Providence 6 ..... GA 6533, GA 1600
McCann, James A., 207 Waterman Street, Providence 6 ..... GA 1862
McCarthy, James M., *(Woonsocket)* 426 Blackstone Street, Woonsocket ..... Woonsocket 44-W
McCaughey, Edward H. *(Pawtucket)* 118 Prospect Street, Pawtucket ..... PE 7660-W
McCoart, Richard F., Jr., 30 Oleyville Square, Providence 9 ..... WE 2099
McCooey, James H., *(Woonsocket)* 99 Main Street, Woonsocket ..... Woonsocket 1747
McGurdy, Gordon J., Box 266, Hollywood, Florida
McCusker, Henry F., 167 Angell Street, Providence 6 ..... DE 4901, GA 1600
McDonald, Charles A., 106 Waterman Street, Providence 6 ..... GA 1711
McDonnell, William A., 20 Highland Avenue, North Providence ..... WE 2131
McEvoy, Frank E., 230 Thayer Street, Providence 6 ..... GA 0578
McGinn, James E., *(Pawtucket)* 19 Stewart Street, Pawtucket ..... PE 0277-W
McGovern, Llewellyn J., 1326 Eddy Street, Providence 5 ..... HO 2125, WI 9009
McIntyre, William A., 475 Elmwood Avenue, Providence 7 ..... WI 6500, GA 1600

McKendry, James R., 568 Hope Street, Providence 6 GA 3272
McKenna, Joseph B., (*Woonsocket*) 162 Main Street, Woonsocket Woonsocket 214-W
McKinney, Samuel, 649 Cranston Street, Providence WE 2414
McLaughlin, Edward A., 600 Broad Street, Providence 7 DE 7470
McOsker, Thomas C., 152 Francis Street, Providence 3 GA 1243
McWilliams, Joseph G., 154 Angell Street, Providence 6 GA 4488
Medoff, Edward B., (*Woonsocket*) Room 204, Hospital Trust Building, Woonsocket Woonsocket 804-W
Mellone, John A., 15 Bay Spring Avenue, West Barrington WArren 0682
Melucci, Alfred F., (*Pawtucket*) 113 West Avenue, Pawtucket PE 0269
Melvin, Edward G., 369 Broad Street, Providence 7 DE 1018
Menzies, Gordon E., 154 West Main Street, Wickford Wickford 23
Merchant, Marcius H., (*Bristol*) 390 Main Street, Warren WArren 0077
Merlino, Frank A., 377 Hope Street, Providence 6 GA 6745
Merrill, Whitman, (*Kent*) 303 Main Street, Washington VAlley 0881
Messinger, Harry C., 210 Angell Street, Providence 6 GA 3028
Metcalf, Cecil J., 198 Angell Street, Providence 6 UN 0494
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Millard, Charles E., (Bristol) 2 Church Street, Warren WArren 0220-W
Miller, Albert H., 28 Everett Avenue, Providence 6 DE 5058
Miller, Henry, 194 Waterman Street, Providence 6 UN 0832
Miller, Himon, 105 Waterman Street, Providence 6 GA 2541
Mills, Parker, 206 Smith Street, Providence 8 GA 1388
Miner, Harold C., 1447 Broad Street, Providence 5 HO 2141
Missirlian, Mihran, 194 Broad Street, Providence 3 GA 5842
Mochnacky, John, 660 Broad Street, Providence 7 GA 4871
Molony, Walter J., 715 Broad Street, Providence 7 WI 1423, GA 1600
Monahan, John T., 160 Academy Avenue, Providence 8 WE 0218
Mongillo, Barrito B., 275 Wayland Aveue, Providence 6 DE 5956
Monti, Emilio J., 214 Broadway, Providence 3 GA 4239
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Moore, James S., 30 John Street, East Providence 14 EA 2074
Moran, James B., 66 Fruit Hill Avenue, Providence WE 1163
Morein, Samuel, 345 Angell Street, Providence 6 GA 0970
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Motta, Gustavo A., 164 Academy Avenue, Providence 8 WE 5554
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Mowry, Jesse E., 211 Washington Avenue, Providence 5 HO 2229
Muller, Gertrude L., 100 North Main Street, Providence DE 1462
Mulvey, William A., 24 Beach Road, Bass Rocks, Gloucester, Massachusetts
Muncy, William M., 162 Angell Street, Providence 6 GA 4385
Murphy, John F., 289 Angell Street, Providence 6 GA 0455
Murphy, Robert G., 184 Angell Street, Providence 6 DE 3424, PL 1923
Murphy, Thomas H., 1008 Smith Street, Providence 8 WE 1256
Myers, Edward L., (*Woonsocket*) 56 Winter Street, Woonsocket Woonsocket 266
Myrick, John C., 513 Cranston Street, Providence 7 WE 3762

N

Nadworny, Adolph J., 15 Warren Avenue, Chelmsford Center, Massachusetts
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Nerone, William S., 21 Bullocks Point Avenue, East Providence 15 EA 4462
Nestor, Michael J., 710 North Mai Street, Providence 4 DE 3030
Nestor, Thomas A., (*Washington*) 69 Kenyon Avenue, Wakefield Narragasett 378
Nevitt, Francis W., 575 Pontiac Avenue, Cranston HO 3500
Nichols, Ira C., Naval Hospital, Philadelphia, Pennsylvania
Normadin, Louis A., 240 Taunton Avenue, East Providence 14 EA 1100
Nourie, Joseph P., 1339 Smith Street, Centerdale CE 0065-W
Noyes, Ira H., 199 Benefit Street, Providence 3 DE 7585

O

O'Brien, James P., (*Woonsocket*) 70 North Main Street, Woonsocket Woonsocket 3665
O'Brien, John H., 95 Taunton Avenue, East Providence EA 0092

continued on next page

ROSTER OF FELLOWS, 1948

O'Brien, William B., State Sanatorium, Wallum Lake ..... Pascoag 22
O'Connell, Francis D., 215 Thayer Street, Providence 6 ..... GA 1441
O'Connell, Joseph C., 215 Thayer Street, Providence 6 ..... GA 9046
O'Connell, Thomas L., 359 Broad Street, Providence 7 ..... GA 3321, DE 1126
O'Connell, William J., 198 Angell Street, Providence 6 ..... GA 1423, GA 1600
O'Connor, John V., (*Woonsocket*) 247 Gaskill Street, Woonsocket ..... Woonsocket 3098
O'Connor, Michael J., 105 Waterman Street, Providence 6 ..... GA 0935
Oddo, Vincent J., 322 Broadway, Providence 9 ..... GA 1461
O'Donnell, Alan E., 21 Elmgrove Avenue, Providence 6 ..... GA 0549
O'Reilly, Edwin B., 737 Smith Street, Providence 8 ..... DE 1132

P

Pahigian, Vahey M., R. I. Hospital, Providence
Palmer, William H., 59 Elmwood Avenue, Providence 7 ..... GA 4328
Palumbo, Joseph A., 118 Pocasset Avenue, Providence 9 ..... WE 2371
Pardee, Katherine, State Sanatorium, Wallum Lake ..... Pascoag 22
Parkinson, James M., 497 Hope Street, Providence 6 ..... PL 3017
Partridge, Herbert G., 190 Angell Street, Providence 6 ..... GA 5544
Paterson, John A., Veterans Administration Hospital, Togus, Maine
Pearson, Rudolph W., 300 Thayer Street, Providence 6 ..... UN 2224
Pedorella, Americo J., 242 Broadway, Providence 3 ..... GA 8218
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Penington, Robert, Jr., U. S. Naval Academy, Annapolis, Maryland
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Petrucci, Ralph J., (*Bristol*) 88 Child Street, Warren ..... WArren 1121
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Pianka, Wallace J., U. S. Veterans Hospital Annex, Vancouver, Washington
Pickles, Wilfred, 184 Waterman Street, Providence 6 ..... GA 1228, GA 1600
Pitts, Herman C., 68 Brown Street, Providence 6 ..... GA 4121
Platt, Marden G. (*Pawtucket*) 123 Massasoit Avenue, Barrington 14 ..... WArren 0414, EA 3836
Porter, Arnold, Children's Hospital, Boston, Massachusetts
Porter, Emery M., 454 Angell Street, Providence 6 ..... PL 2440, GA 1600
Porter, Lewis B., 199 Thayer Street, Providence 6 ..... GA 3970
Portnoy, Bradford M. S., 672 Broad Street, Providence 7 ..... GA 4235
Potter, Alfred L., 171 Angell Street, Providence 6 ..... DE 3241, GA 1600
Potter, Charles, 223 Thayer Street, Providence 6 ..... DE 1311
Potter, Edgar S., (*Woonsocket*) Chepachet ..... Pascoag 124
Potter, Henry B., (*Washington*) Wakefield ..... Narragansett 123
Potter, Merle M., 224 Thayer Street, Providence 6 ..... GA 9184
Potter, Walter H., 68 Jackson Street, Providence 3 ..... GA 4476
Pournaras, Nicholas A., 499 Elmwood Avenue, Providence 7 ..... WI 3022
Pozzi, Gustave, 209 Waterman Avenue, East Providence 14 ..... EA 0330
Prior, James H., 1738 Broad Street, Edgewood 5 ..... HO 1414
Pritzker, Samuel, 179 Wheeler Avenue, Providence 5 ..... UN 0070, WI 7373
Putnam, Helen C., (*no district society*) 312 Laurel Avenue, Providence 6 ..... PL 4059

Q

Quesnel, Ernest, State Hospital, Howard ..... HO 4700

R

Rakatansky, Nathan S., 51 Beacon Circle, Cranston 10 ..... WI 8788
Ramos, Jose M., (*Newport*) 28 Kay Street, Newport ..... Newport 85
Randall, Arthur G., (*No district society*) 511 Westminster Street, Providence 3 ..... GA 2614
Rapoport, Bernard, 169 Waterman Street, Providence 6 ..... DE 1934
Rattenni, Arthur, 1011 Smith Street, Providence 8 ..... WE 6327
Reeves, James A., 1404 Broad Street, Providence 5 ..... HO 2224, GA 1600
Regan, John F., State Hospital for Mental Diseases, Howard ..... HO 4700
Rego, Rodrigo P. daC., 103 Governor Street, Providence 6 ..... DE 7753
Reich, Jacob, 450 Prairie Avenue, Providence 5 ..... WI 3661
Reid, William A., 300 Thayer Street, Providence ..... GA 3300
Reilly, Joseph W., (*Woonsocket*) 113 Main Street, Woonsocket ..... Woonsocket 242-R
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continued on page 634



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continued from page 632

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Riley, Clarence J., 507 Manton Avenue, Providence 9 — WE 2300
Ripley, Frederic W., Jr., 167 Angell Street, Providence 6 — GA 6431, GA 1600
Rittner, Mark, 533 Elmwood Avenue, Providence 7 — WI 5577
Roberts, William H., 448 Hope Street, Providence 6 — DE 1535
Robinson, Mildred I., (*Washington*) 21 Grove Avenue, Westerly — Westerly 2234
Robinson, Nathaniel D., (*Pawtucket*) Apt. 10, Larch Street Veterans Housing, Fox Hills, Staten Island, New York
Robinson, Robert C., 133 Waterman Street, Providence 6 — GA 1892
Rocheleau, Walter C., (*Woonsocket*) 38 Hamlet Avenue, Woonsocket — Woonsocket 2067
Rohr, Mary-Elaine J., (*Pawtucket*) 358 Pawtucket Avenue, Pawtucket — BL 2425-W
Romano, Anthony, 462 Broadway, Providence 9 — UN 3577
Ronchese, Francesco, 170 Waterman Street, Providence 6 — GA 3004
Ronne, George E., (*Pawtucket*) 49 Fountain Street, Pawtucket — PE 3015
Roque, John A., 126 Garden Street, Cranston — WI 1131
Ross, Florence M., 55 Bluff Avenue, Edgewood Station, Providence 5 — WI 7868
Ross, Milton T., 355 Thayer St., Providence — GA 8671
Rossi, Matthew W., 784 Park Avenue, Cranston 10 — WI 8688
Rossignoli, Vincent P., 201 Broadway, Providence 3 — DE 2358
Roswell, Joseph T., (*Woonsocket*) 50 Providence Street, Woonsocket — Woonsocket 74
Rounds, Albert W., 511 Westminster Street, Providence 3 — GA 2927
Rozzero, Paul J., 176 Wesbster Avenue, Providence 9 — WE 3344
Ruggles, Arthur H., Butler Hospital, Providence 6 — GA 3456
Ruhmann, Edward F., 1711 Broad Street, Cranston 5 — HO 5523
Ruhmnn, Warren H., (*Kent*) 4648 Post Road, East Greenwich — Greenwich 7-W
Ruisi, Joseph L. C., (*Washington*) 21 Elm Street, Westerly — Westerly 4281
Russell, Amy E., 651 Warren Avenue, East Providence 14 — EA 0090-R
Ryan, J. Frank, 1397 Broad Street, Providence 5 — WI 1232
Ryan, Jerome J., 250 Elmwood Avenue, Providence 7 — JA 3232
Ryan, Vincent J., 198 Angell Street, Providence 6 — GA 4313, GA 1600

S

Sage, Louis A., 122 Waterman Street, Providence 6 — GA 8435
St. Angelo, Joseph A., 1891 Smith Street, North Providence 11 — CEnterdale 0167
Saklad, Elihu, 252 George Street, Providence 6 — GA 0026
Saklad, Meyer, 252 George Street, Providence 6 — GA 0026
Saklad, Sarah M., 153 Morris Avenue, Providence 6 — GA 0477
Sammartino, Agostino, 257 Academy Avenue, Providence 8 — WE 4081-W
Sanborn, Harvey B., 112 Waterman Street, Providence 6 — GA 4253
Sannella, Lee G., 124 Waterman Street, Providence 6 — GA 9433
Sarafian, John C., 593 Broad Street, Providence 7 — DE 1146, GA 3333
Sargent, Francis B., 124 Waterman Street, Providence 6 — GA 4422
Savastano, Americo A., 102 Waterman Street, Providence 6 — GA 4538
Savran, Jack, 295 Angell Street, Providence 6 — PL 2112, GA 1600
Sawyer, Carl D., 184 Waterman Street, Providence 6 — GA 1582
Sawyer, Carl S., 184 Waterman Street, Providence 6 — DE 3355
Sayer, Edmund A., 148 Waterman Street, Providence 6 — PL 0148
Scanlan, Michael H., (*Washington*) 88 High Street, Westerly — Westerly 2190
Scanlon, Thomas F., 366 Atwells Avenue, Providence 3 — GA 0847
Schiff, Bencel L., (Pawtucket) 251 Broadway, Pawtucket — BL 3175
Schradieck, Constant E., General Delivery, Germantown P. O., Philadelphia 44, Pa.
Schwab, William J., 616 Hope Street, Providence 6 — DE 1279
Scorpio, Angelo, 236 Broadway, Providence 3 — DE 3333
Scotti, Ciro O., 770 Providence Street, West Warwick — VA 0465
Segall, Werner, 155 Angell Street, Providence 6 — JA 1801
Sellman, Priscilla, 21 Lorimer Avenue, Providence 6 — PL 6234
Seltzer, Bernard B., 300 Pontiac Avenue, Cranston 10 — WI 0094
Seltzer, Edward I., 300 Pontiac Avenue, Cranston 10 — WI 0094
Senerchia, Giovanni, (*Kent*) 525 Providence Street, West Warwick — VA 0569
Senseman, Laurence A., (*Pawtucket*) 1189 Smithfield Avenue, Lincoln — PE 4484
Sharp, Benjamin S., 339 Thayer Street, Providence 6 — DE 0929
Sharp, Ezra A., 339 Thayer Street, Providence 6 — GA 1751, GA 1600
Shattuck, George L., 150 George Street, Providence 6 — GA 7590
Shaw, Eliot A., c/o North Scituate P. O., Foster
Sheehan, John J., 551 Hope Street, Providence 6 — PL 1214

Sheehan, Linus A., 210 Angell Street, Providence 6 GA 3028
Sheridan, James J., (*Pawtucket*) 329 Broad Street, Central Falls PE 0233-W
Sheridan, Thomas P., 92 Prosvect Street, Pawtucket PE 4633
Sherman, Bernard I., 1045 Broad Street, Providence 5 WI 4154
Shields, William P., 221 Thayer Street, Providence 6 GA 2323, GA 1600
Silver, Caroll M., 155 Angell Street, Providence 6 UN 2021, GA 3333
Smith, Bruce W., 203 Thayer Street, Providence 6 GA 2221, GA 1600
Smith, Clara L., 281 Olney Street, Providence 6 GA 5407
Smith, Daniel A., (*Newport*) 29 Mary Street, Newport Newport 3950
Smith, Frederick A., (*No district society*) 525 Hope Street, Providence 6 GA 3395
Smith, Joseph, City Hall, Providence 3 GA 7740
Smith, Orland F., (*Pawtucket*) 275 Angell St., Providence UN 1010
Sonkin, Nathan, 251 Broadway, Pawtucket BL 4398
Southey, Charles L., 900 Park Avenue, Cranston 10 HO 2332
Sperber, Perry, 136 Elmwood Avenue, Providence 7 DE 3620
Spicer, Albert D., (*Washington*) 23 Broad Street, Westerly Westerly 2561
Sprague, Stanley, (*Pawtucket*) 101 Broadway, Pawtucket PE 3987-W
Stephens, H. Frederick, 195 Thayer Street, Providence 6 GA 3867
Stevens, Raymond E., (*Pawtucket*) 398 Greenwood Avenue, Rumford 16 EA 2508
Stevens, Raymond T., 92 Taunton Avenue, East Providence 14 EA 3933-W
Stewart, Frank A., (*Newport*) 34 Bull Street, Newport Newport 5940
Stone, E. Franklin, 1509 Westminster Street, Providence 9 UN 4141, UN 6215
Stone, Ellen A., 280 Waterman Street, Providence 6 PL 5289
Stone, Eric P., Cushing General Hospital, Framingham, Massachusetts
Stone, Jacob, 226 Waterman St., Providence 6 DE 6829
Storrs, Berton W., (*Newport*) Main Road, Portsmouth Portsmouth 20
Streker, Edward T., 903A Broad Street, Providence WI 7476
Streker, John F., 903 Broad Street, Providence 7 WI 1244, WI 1432
Sullivan, James F., (*Pawtucket*) 84 Broad Street, Pawtucket PE 1832-W
Sullivan, Michael H., (*Newport*) 60 Touro Street, Newport Newport 508
Sullivan, Ralph V., 1192 Westminster Street, Providence 9 GA 1002
Sweeney, John W., 624 Elmwood Avenue, Providence 7 HO 5078, GA. 1600
Sweet, Charles F., (*Pawtucket*) 69 Dryden Avenue, Pawtucket PE 0532
Sweet, Gustaf, 105 Waterman Street, Providence 6 GA 1979
Sydlowski, Edmund J., 66 Doyle Avenue, Providence 6 GA 3050

T

Taft, George Henry, 8 Myrtle Street, Providence PL 0091
Taggart, Fenwick G., (*Kent*) 1 Montrose Street, East Greenwich Greenwich 334
Tanguay, J. Edgar (*Woonsocket*) 281 Harris Avenue, Woonsocket Woonsocket 440
Tarro, Michael A., 973 Atwells Avenue, Providence 3 WE 3424
Tartaglino, Alfred M., (*Newport*) 75 Pelham Street, Newport Newport 4190
Tatum, Julianna R., (*Washington*) 8 Margin Street, Westerly Westerly 2636
Tefft, Benjamin F., (*Kent*) 185 Washington Street, West Warwick VAlley 0229
Temple, Francis E., 1527 Warwick Avenue, Hoxsie BA 1265
Tetreault, Adrien G., (*Pawtucket*) 650 Central Avenue, Pawtucket PE 8778
Thewlis, Malford W., (*Washington*) 25 Mechanic Street, Wakefield Narragansett 4
Thomas, Alton P., (*Woonsocket*) 18 Monument Square, Woonsocket Woonsocket 6846
Thompson, Edward R., (*Pawtucket*) 18 Exchange Street, Room 218-220, Pawtucket BL 0132
Thompson, Edwin G., 68 Pocasset Avenue, Providence 9 WE 0041
Thompson, Ernest D., 90 Waterman Street, Providence 6 UN 1115, GA 1600
Thompson, William C., Washington Trust Building, Westerly Westerly 4770
Tingley, Louisa P., 171 Westminster Street, Providence 3 GA 5922
Tollefson, George A., (*Newport*) 12 Kay Street, Newport Newport 6349
Trainor, Edward H., (*Pawtucket*) 69 Walcott Street, Pawtucket PE 1033
Tremblay, Euclide L., (*Woonsocket*) 66 Hamlet Avenue, Woonsocket Woonsocket 4477-R
Triedman, Harry, (*Pawtucket*) 33 Cottage Street, Pawtucket PE 5420-W
Troppoli, Daniel V., 380 Broadway, Providence 9 UN 3325
Trott, Raymond H., 219 Waterman Street, Providence 6 GA 1721, GA 1600
Tully, William H., Jr., (*Washington*) 32 Lake Street, Wakefield Narragansett 80
Turco, Salvatore J. P., (*Washington*) 170 High Street, Peace Dale Narragansett 34
Turner, Charles S., 973 Broad Street, Providence 5 WI 4114
Turner, Henry E., (*Pawtucket*) 101 Broadway, Pawtucket BL 3083
Turner, Howard K., 199 Thayer Street, Providence 6 GA 7368, GA 1600
Turner, J. Lincoln, (*Pawtucket*) 101 Broadway, Pawtucket PE 0594
Tweddell, Henry J., (*Woonsocket*) 115 Cass Street, Woonsocket Woonsocket 5322

continued on next page

ROSTER OF FELLOWS, 1948

U

Umstead, Howard W., (*Pawtucket*) 188 Main Street, Pawtucket ..... BL 1924
Utter, Henry E., 122 Waterman Street, Providence 6 ..... GA 2147

V

Vallone, John J., 270 Elmwood Avenue, Providence 7 ..... JA 2433
Van Benschoten, George W., 195 Thayer Street, Providence 6 ..... GA 3867
Vaughn, Arthur H., 137 Warren Avenue, East Providence 14 ..... EA 1721
Verrone, Anthony C., 1574 Cranston Street, Cranston 9 ..... UN 0460, GA 3333
Vian, George M., (*Woonsocket*) 308 Stadium Building, Woonsocket ..... Woonsocket 5914-W
Vidal, Jeannette E., (*Kent*) 14 St. John Street, West Warwick ..... VA 0544
Vieira, Edwin, 221 Warren Avenue, East Providence 14 ..... EA 2248
Visgilio, Thomas, Jr., (*Washington*) Room 415, Washington Trust Building, Westerly ..... Westerly 2509
Votta, Paul J., St. Joseph's Hospital, Providence 7 ..... DE 2509

W

Walsh, John G., 221 Thayer Street, Providence 6 ..... GA 1710
Warren, Jacob R., (*Washington*) 59 Elm St., Westerly ..... Westerly 2616
Waterman, George W., 155 Thayer Street, Providence 6 ..... DE 4229, GA 1600
Webber, Joseph B., 730 Broad Street, Providence 7 ..... HO 5431
Webster, Frederick A., (*Pawtucket*) 112 Waterman Street, Providence 6 ..... JA 4258
Welch, Stephen A., 253 Washington Street, Providence ..... GA 1333
Westcott, Clinton S., 454 Angell Street, Providence 6 ..... PL 2440
Westcott, Niles, Butler Hospital, Providence 6 ..... GA 3456
Weyler, Henry L. C., 335 Angell Street, Providence 6 ..... GA 0720
Wheaton, James L., (*Pawtucket*) 164 Broadway, Pawtucket ..... PE 2102
Whipple, Richard K., 122 Waterman Street, Providence 6 ..... DE 1700
White, George F., 1300 Elmwood Avenue, Cranston 7 ..... WI 3131, GA 1600
Whitmarsh, Robert H., 154 Angell Street, Providence 6 ..... GA 3061, GA 1600
Wilcox, Roswell S., 1374 Eddy Street, Providence 5 ..... WI 4224
Williams, Harold W., 129 Waterman Street, Providence 6 ..... UN 0459, GA 1600
Williams, Pearl, 371 Broad Street, Providence 7 ..... GA 1966
Williams, Robert J., Rhode Island Hospital, Providence ..... DE 4300
Windsberg, Eske, 203 Thayer Street, Providence 6 ..... PL 4343
Wing, Elihu S., 155 Thayer Street, Providence 6 ..... GA 3314
Winkler, Herman A., 224 Thayer Street, Providence 6 ..... GA 4010, GA 1600
Winkler, Malcolm, 199 Thayer Street, Providence 6 ..... DE 0105, GA 1600
Wise, Bernard O., Box 291, Phoenixville, Pennsylvania
Wittes, Saul A., (*Woonsocket*) Stadium Building, Woonsocket ..... Woonsocket 5910-W
Wittig, Joseph E., (*Kent*) 331 Washington Street, West Warwick ..... VAlley 0919
Wolfe, Hattie G., State Hospital, Howard ..... HO 4700
Woodcome, Harold A., (*Pawtucket*) 156 Broadway, Pawtucket ..... BL 2907-W
Wright, David G., Butler Hospital, Providence ..... GA 3456

Y

Yessian, Mark A., 184 Elmwood Avenue, Providence 7 ..... DE 6613
Young, Daniel D., 134 Francis Street, Providence 3 ..... GA 7517, GA 3333
Young, George L., (*Kent*) 4640 Post Road, East Greenwich ..... Greenwich 614-W
Young, John A., (*Newport*) 253 Broadway, Newport ..... Newport 956

Z

Zambarano, Ubaldo E., State Sanatorium, Wallum Lake ..... Pascoag 22
Zamil, Edward (*Newport*) 99 Touro Street, Newport ..... Newport 6616-W
Zecchino, Vincent, 185 Angell Street, Providence 6 ..... UN 9000
Zielinski, Norbert U., (*Newport*) 27 Kay Street, Newport ..... Newport 623
Zimdahl, Walter T., (1st Lt., MC, 047190) Brooke General Hospital, Annex 4, Fort Sam Houston, Texas
Zinno, Genarino R., 334 Branch Avenue, Providence 4 ..... GA 6534
Zolmian, Hrad H., (*Pawtucket*) 116 Mineral Spring Avenue, Pawtucket ..... BL 0143
Zouraboff, Catherine, 167 Julia Street, Cranston 10 ..... WI 4485
Zucker, Joseph M., Mental Hygiene Clinic, Veterans Administration, Providence ..... JA 5050
Zurawski, Charles, 30 Olneyville Square, Providence 9 ..... WE 3581-M

PHYSICAL EXAMINATIONS FOR NATIONAL SERVICE LIFE OR UNITED STATES GOVERNMENT LIFE INSURANCE

The Branch Insurance Service has requested that the following information be circularized to physicians in New England:

"Where physical examination is required by an applicant for National Service Life Insurance or United States Government Life Insurance, such examination may be made at the applicant's own expense by a physician duly licensed for the practice of medicine by a State, Territory of the United States, or the District of Columbia, who is not related to the applicant by blood or marriage, associated with him in business, or pecuniarily interested in the issuance or reinstatement of the insurance.

"When a physician makes examination of an applicant for National Service Life Insurance, it is requested that the physician not return completed application to the applicant, but forward same to Veterans Administration, Insurance Service, Branch Office No. 1. 55 Tremont St., Boston, Mass. with a postmark date not later than 5 days from the date of examination.

"When a physician makes examination in connection with United States Government Life Insurance, it is requested that the physician forward completed application to Veteran's Administration, Insurance Service, Washington 25, D. C. with a postmark date not later than 5 days from the date of making examination."

It is suggested that the information be incorporated in any instruction bulletins your office issues to community physicians or in the monthly publications of your State Medical Society.

FRANCIS B. CARROLL, M.D.
Branch Medical Director
Veterans Administration

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1. Kasper, J. A. and Jeffrey, I. A.: A Simplified Benedict Test for Glycosuria, Amer. J. Clin. Pathology, *14*:117-21 (Nov.) 1944.

2. Haid, W. H.: The Use of Screening Tests in the Clinical Laboratory, J. Amer. Med. Tech., *8*:606-14 (Sept.) 1947.

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BOOK REVIEWS

A MANUAL OF PHARMACOLOGY AND ITS APPLICATION TO THERAPEUTICS AND TOXICOLOGY, By Torald Sollmann, M.D. Phil.: W. B. Saunders Company. 7th ed., 1948. $11.50

This revised edition of Sollmann's book has some outstanding characteristics which make it an advance in pharmacological text books. The subject matter is presented in a manner which integrates the material discussed with its clinical applications. This characteristic is emphasized if the treatment of subject material in the new edition is compared with an older edition.

The present volume very adequately covers advances in such fields as the antibiotic agents, the antihistaminics, and the nitrogen mustards. The treatment of the older drugs is characterized by the emphasis on well established recent facts and the elimination of unnecessary speculation.

The bibliography is quite complete and the new arrangement of two columns to a page makes for easier reading.

W. J. H. Fischer, Jr., M.D.

"MEDICAL WRITING — THE TECHNIC AND THE ART"

by Morris Fishbein, M. D.
The Blakiston Company

This book summarizes the ideas of the Journal of the American Medical Association as to how such writing should be done. It is complete and authoritative and anyone who masters it should be quite competent to write a good medical article. Provided, of course, that in his spare moments he has become acquainted with some pertinent medical matters.

In chapter two we read "Whenever a writer feels an impulse to perpetrate a piece of exceptionally fancy writing, he should obey it but should delete what he has written before sending the manuscript to press." In the introduction Dr. Fishbein says, ". . . physicians . . . prepare contributions with a striving and agony and delay comparable to the delivery of human progeny by one untutored in the possible refinements associated with that performance." The undeleted fine writing here has me wondering whether the principara or the accoucher is suffering the agony.

We will have to take some of the doctor's pronouncements ex cathedra. Why is adrenal better than suprarenal while epinephrine is better than adrenalin? Why can't we use the one word "mongolian" as Webster does, instead of "person afflicted with neongolism" as Fishbein does?

Boswell appealed to Johnson for his opinion when a citizen of Edinboro sued because he had been designated doctor in a formal document and he preferred physician. Johnson upheld the dignity of the title Doctor. Fishbein says use physician. I am so vacillating that if I needed one of the words several times in an article I would alternate.

But despite the finding of few little pet foibles of Dr. Fishbein, I think this is a mighty good book. I wish every writer of a medical paper would spend a little while looking it over and I think every medical editor should keep it next to Fowler's Modern English Usage.

PETER PINEO CHASE, M.D.

PRACTICE OF ALLERGY

Vaughan, Black

C. V. Mosby Co. 1948

The first edition of the Practice of Allergy appeared in 1939 and was written by Warren Vaughan. Unfortunately he did not live to complete the second edition of his book. The task of bringing it to full fruit fell upon the shoulders of Harvey Black.

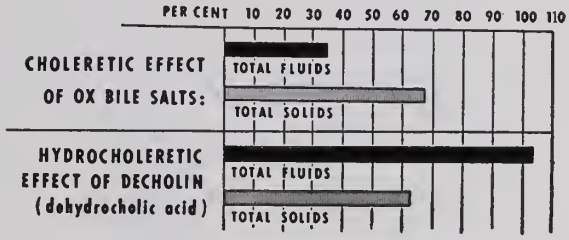
The book has 1131 pages and is divided into 79 Chapters. The main division of the book embraces Development, General Characteristics of Clinical Allergy, Physiology, Allergic Diagnosis, Food Allergy and Allergens, Pollens and other Inhalants, Bacteria, Fungi, Drugs, Contact Allergy, Physical Allergy, Pharmacology, and Allergic Diseases.

The text is printed on a good grade of paper. The type is well set and does not strain the eyes. The style of writing makes the book very readable. One does not get lost in a maze of words and nebulous fantasia. The Practice of Allergy is a practical work and can be easily understood by one not well versed in allergy.

Allergic terminology is simply stated. Avoidance of the term hypersensitivity (a person is either sensitive or not) and desensitization (should be hyposensitization) is suggested. Under basic pathology and through out the book the three characteristics of allergy are emphasized — 1) smooth muscle spasm, 2) increased capillary permeability, 3) eosinophilia. In urticaria, migraine, and allergic renal colic the allergic reaction is usually reversible while in asthma, eczema, and colitis the return to normal is usually not complete. Irreversible changes cause smooth muscle hypertrophy, polyposis, Arthrus phenomenon and periarteritis nodosa. All that can be safely said of histamine is that it fluctuates more in the blood of the allergic than the normal person. The use of the antihistaminics can not be justified on the fact that they are antagonists to histamine. For while they work in hay fever they fail in other manifestation of allergy, thus disposing

continued on next page

DECHOLIN HYDROCHOLERESIS Encourages Biliary Tract Drainage



● **Percentage Increase in Composition and Quantity of Bile Flow**

Ivy, A. C., et al: Am. J. Dig. Dis. 7:333 (Aug.) 1940.

HYDROCHOLERESIS—

an increased production of thin liver bile—is a desirable approach to therapy of non-obstructive biliary tract disturbances.

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by producing an increased flow of bile—washes stagnant, infected bile from the intrahepatic and extrahepatic biliary passages, removing pus-laden material and discouraging the ascent of infection.

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BOOK REVIEW

concluded from preceding page

of the histamine theory as the protean etiology of allergic reactions.

Vaughan and Black devote time to the relationship between psychiatry and allergy. Psychomatic allergic reactions are being given serious study these days.

The section on food allergy is quite exhaustive. The author believes in group testing of related foods and has them arranged in this fashion. The chapters on pollen surveys and aerobiology were written by Oren C. Durham of the Abbott Laboratories. These are excellent. The illustrations and descriptions of the botanical inhalants are quite detailed.

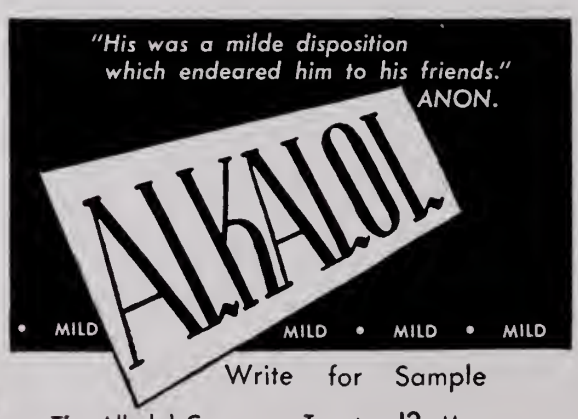
Sizeable sections are devoted to bacterial and mold allergy, contrasting with the meager material once devoted to this subject. J. B. Howell wrote the chapter on mold allergy combining dermatological knowledge with the subject of allergy. Drugs are adequately handled and long lists are given. Contact allergy to plants, animal products, drugs, chemicals, and cosmetics are well treated. Tables and methods of testing are offered.

Under allergic diseases are listed asthma, hay fever, migraine, gastrointestinal allergic disorders, certain cardiovascular diseases, and a miscellaneous group comprising Loeffler's syndrome, epilepsy, Meniere's disease, arthritis, otologic and ocular allergy.

No mention is made of allergic phenomena relating to blood groupings, transfusion reactions, the Rh factor, Landsteiner's work or the recent work of Wiener who has shown the presence of monovalent and bivalent antibodies with their important relationship to allergic and immune states.

In conclusion I might quote the author "Allergy is not a pathologic state. It is a pathologic exaggeration of a normal physiologic response. The probability is that the development of sensitization to foreign substances is almost a normal physiologic function. If all of us were to live long enough 100% of the population would develop at least a minor allergy".

FERRY SPERBER, M.D.



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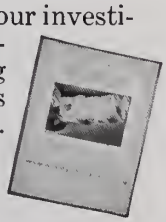
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In Canada: Fiberglas Canada Ltd., Toronto, Ontario.

†Glaser, Jerome, M.D. Treatment of eczema (atopic dermatitis) in infancy. J.A.M.A. 137: 6 (June 5) 1948, pp.527-531.

††*Manufacturers:* Albert Richard Division of Fried, Ostermann Company, 1645 South Second Street, Milwaukee 4, Wisconsin; Cresco Mfg. Co., 703 Union Street, Ashland, Ohio; Excel Garment Manufacturing Company, 310 Second Avenue, N., Minneapolis 1, Minnesota; Gordon & Ferguson, Inc., 230 East Fifth Street, St. Paul 1, Minnesota; Klinkerfues Brothers Co., 910-7 East Seventh Street, St. Paul 6, Minnesota. *Retail:* Montgomery Ward, Chicago (see pp. 421 and 427 of Fall and Winter 1948-1949 Catalog). Names of retail clothing and department stores may be obtained from any of the manufacturers listed above.

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WEDNESDAY, NOVEMBER 3, 1948

MORNING SESSION

10:00 a.m. CLINICAL INDICATIONS FOR THE USE OF THE NEWER ANALGESIC DRUGS WITH NOTES ON THEIR ADDICTION LIABILITIES
HARRIS ISBELL, M.D., *Director of Research Division, U. S. Public Health Service Hospital, Lexington, Kentucky*

10:30 a.m. THE CAUSES OF INDIGESTION AND THEIR TREATMENT
WALTER L. PALMER, M.D., *Professor of Medicine, University of Chicago*

11:00 a.m. 15 MINUTE INTERMISSION

11:15 a.m. NEWER AGENTS IN THE TREATMENT OF CANCER
CORNELIUS RHOADS, M.D., *Director, Memorial Hospital and Sloan-Kettering Institute for Cancer Research.*

11:45 a.m. MANAGEMENT OF THE COMPLICATIONS OF PEPTIC ULCER: INDICATIONS FOR TREATMENT.
WALTER L. PALMER, M.D.

12:15 p.m. LUNCHEON: COPLEY PLAZA HOTEL. Subject to be announced.
CORNELIUS P. RHOADS, M.D.

AFTERNOON SESSION

2:00 p.m. NEWER CHEMOTHERAPEUTIC APPROACHES TO VIRUS DISEASE.
JOHN H. DINGLE, M.D., *Professor of Preventive Medicine, Western Reserve University School of Medicine, Cleveland*

2:30 p.m. LOW SALT REGIME AND OTHER MEASURES IN THE TREATMENT OF CONGESTIVE HEART FAILURE
HAROLD M. MARVIN, M.D., *Associate Professor of Medicine, Yale University School of Medicine*

3:00 p.m. NEWER CHEMOTHERAPEUTIC APPROACHES TO RICKETTSIA DISEASES
JOHN H. DINGLE, M.D.

3:30 p.m. 15 MINUTE INTERMISSION

3:45 p.m. EARLY HANDLING OF THE SEVERELY INJURED
ROBERT KENNEDY, M.D., *Chairman, Fracture Committee of the American College of Surgeons*

4:15 p.m. THE CLINICAL MANAGEMENT OF ACUTE CORONARY OCCLUSION
WILLIAM D. STROUD, M.D., *Professor of Cardiology, University of Pennsylvania Graduate School of Medicine*

4:45 p.m. PITFALLS IN THE TREATMENT OF FRACTURES
ROBERT KENNEDY, M.D.

THURSDAY, NOVEMBER 4, 1948

MORNING SESSION

10:00 a.m. THE SURGICAL TREATMENT OF GASTRIC AND DUODENAL ULCER
G. GAVIN MILLER, M.D., *Associate Professor of Surgery, McGill University*

10:30 a.m. THE USE OF ESTROGENS IN WOMEN
EPHRAIM SHORR, M.D., *Associate Professor of Medicine, Cornell University Medical College*

11:00 a.m. 15 MINUTE INTERMISSION

11:15 a.m. THE RECOGNITION AND MANAGEMENT OF INTESTINAL OBSTRUCTION
G. GAVIN MILLER, M.D.

11:45 a.m. THE USE OF ANDROGENS IN WOMEN
EPHRAIM SHORR, M.D.

12:15 a.m. LUNCHEON: COPLEY PLAZA HOTEL
THE PRESENT STATUS OF TETANUS IMMUNIZATION
CONRAD WESSELHOEFT, M.D., *Clinical Professor of Infectious Diseases, Harvard School of Public Health*

AFTERNOON SESSION

2:15 p.m. WHAT THE RH FACTOR IS NOT
LOUIS K. DIAMOND, M.D., *Assistant Professor of Pediatrics, Harvard Medical School*

2:45 p.m. OPHTHALMOLOGY
ALBERT D. RUEDEMANN, M.D., *Professor of Ophthalmology, Wayne University School of Medicine, Detroit*

3:15 p.m. 15 MINUTE INTERMISSION

3:30 p.m. THE MANAGEMENT OF THE POTENTIALLY INFECTED OBSTETRICAL CASE
EDWARD G. WATERS, M.D., *Assistant Clinical Professor of Obstetrics and Gynecology, College of Physicians and Surgeons*

4:00 p.m. OPHTHALMOLOGY
ALBERT D. RUEDEMANN, M.D.

7:00 p.m. DINNER: COPLEY PLAZA HOTEL
Speaker and subject to be announced

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Clinics will be conducted during the morning at various hospitals in metropolitan Boston. The time, location, conductor and subject of each clinic will be announced.

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The registration fee is $2.00, and should be forwarded by mail, if possible. Dinner will be $3.50 and the luncheons $2.50 each. Members may invite guests to luncheon and dinner if reservations are made in advance.

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*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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Table of Contents Page 655



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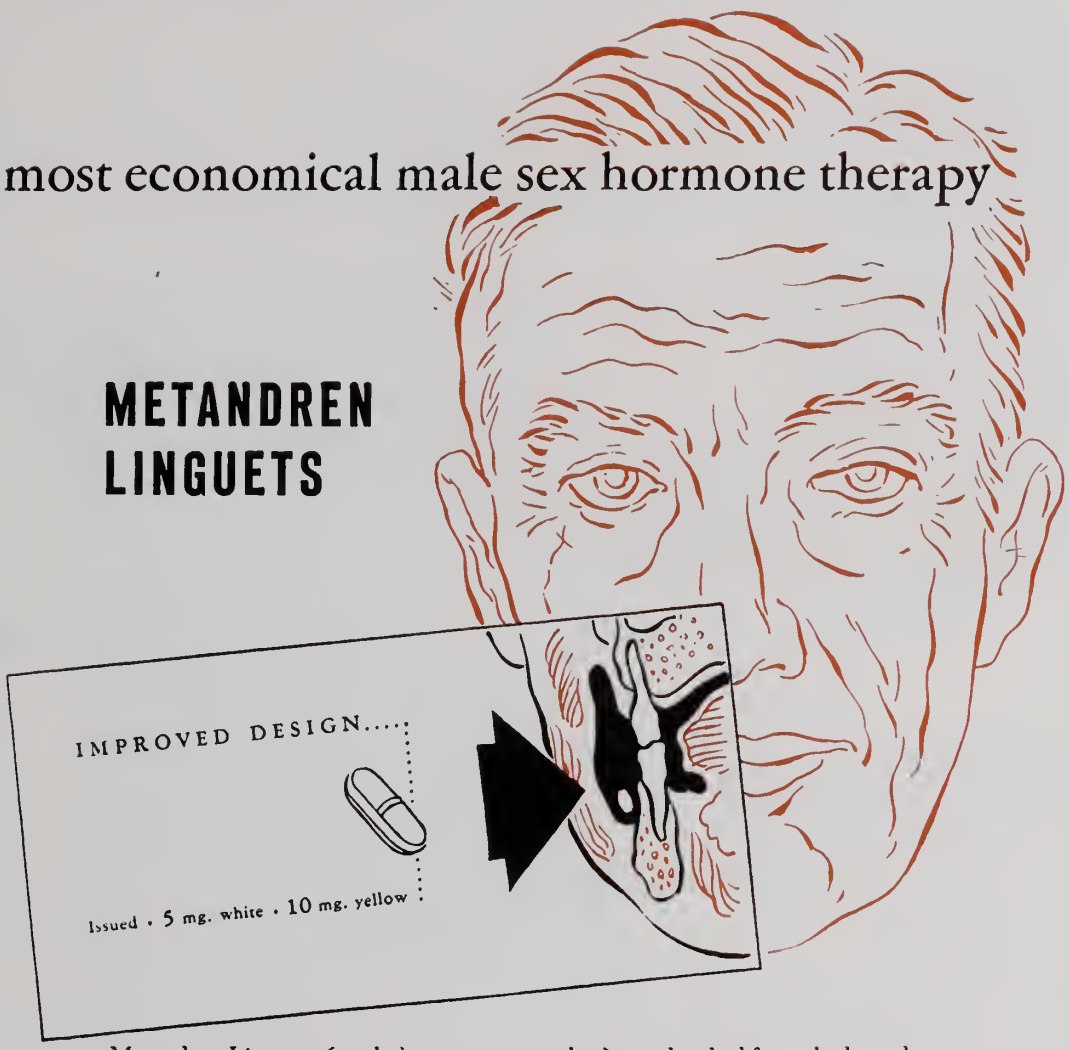
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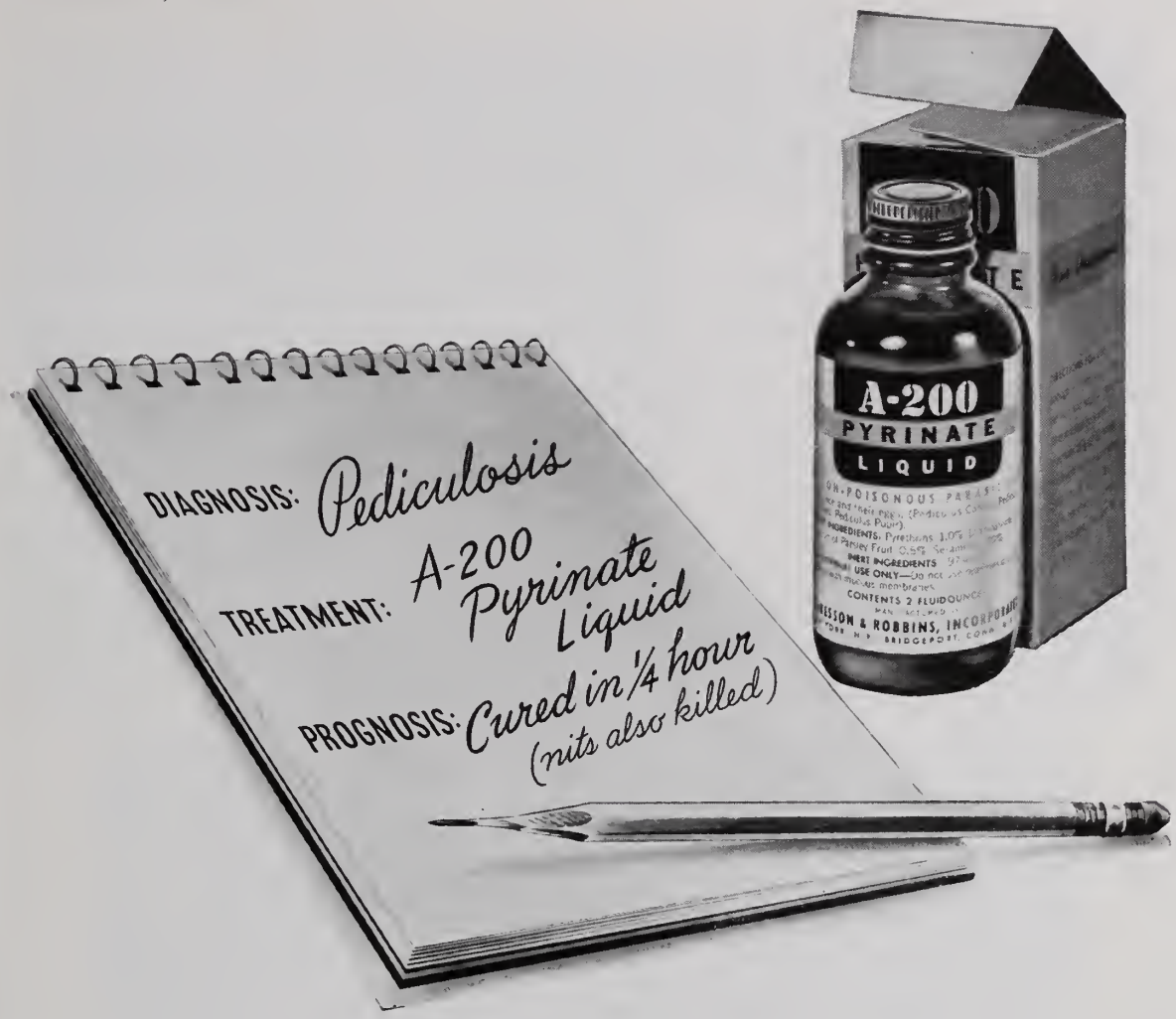
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Vol. XXXI, No. 11 November, 1948

TABLE OF CONTENTS

PAGE

The Etiology and Treatment of Chronic Ulcerative Colitis (Non-Specific)
Anthony Bassler, M.D. 663

Bilateral Non-Simultaneuous Femoral Arterial Embolic Occlusion
Jesse P. Eddy, III. M.D. 669

EDITORIALS

Surgery in Germany 672

The Blue Cross — Blue Shield Merger 674

DEPARTMENTS

District Medical Society Meetings 676

House of Delegates (Report of Meeting of September 29, 1948) 688

Through the Microscope 684

Book Reviews 696

MISCELLANEOUS

Index of Advertisers 659

Providence Medical Association Golf Winners 680

Ready to Help the Cardiac Child 699

Participating Physicians in R. I. Surgical Plan 701



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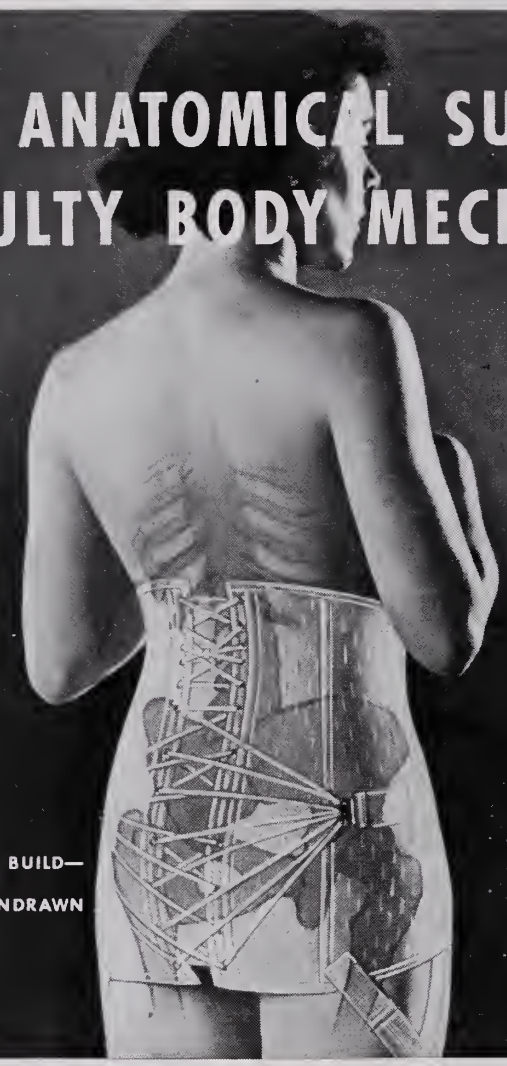
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INDEX OF ADVERTISERS

	PAGE
Abbott Laboratories	682
Akalol Company	692
American Meat Institute	661
Ames Company, Inc.	686
E. P. Anthony, Inc.	659
Ar-Ex Cosmetics, Inc.	698
Arlington Chemical Company	677
Ayerst, McKenna & Harrison	657
Bayview Convalescent Home	698
Blanding & Blanding	703
J. E. Brennan & Company	654
George A. Breon and Company	694
Joseph Brown Company	654
Butterfield Drug Stores	654
Camel	662
S. H. Camp Company	660
Ciba Pharmaceutical Products, Inc.	649, 679
Curran & Burton	698
J. E. Hanger, Inc.	654
H. P. Hood & Sons	656
Eli Lilly & Company	insert 662-663
McCaffrey, Inc.	654
McKesson and Robbins, Inc.	651
S. E. Massengill Company	691
Mead Johnson & Company	Back Cover
Medical Milk Commission	697
A. B. Munroe Dairy	699
Mutual Benefit Health and Accident Association	652
Narragansett Brewing Company	700
Neland Pharmaceuticals, Inc.	683
Nestle's Milk Products	653
Parke Davis & Company	inside back cover
Philip Morris & Company	650
Physicians Directory	658-659
R. I. Limb Company	678
Schenley Laboratories, Inc.	687
Schering Corporation	689
G. D. Searle & Company	675
Sharpe & Dohme, Inc.	685
Smith-Holden, Inc.	704
E. R. Squibb & Sons	inside front cover
Strand Optical Company	698
Upjohn Company	681
Warwick Club Beverages	693
White Rock Bottling Company of Rhode Island	654
Winthrop-Stearns, Inc.	695

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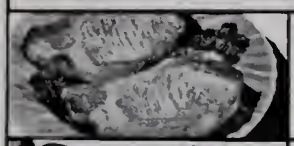
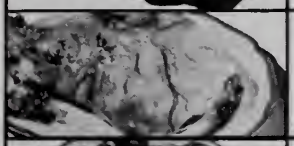
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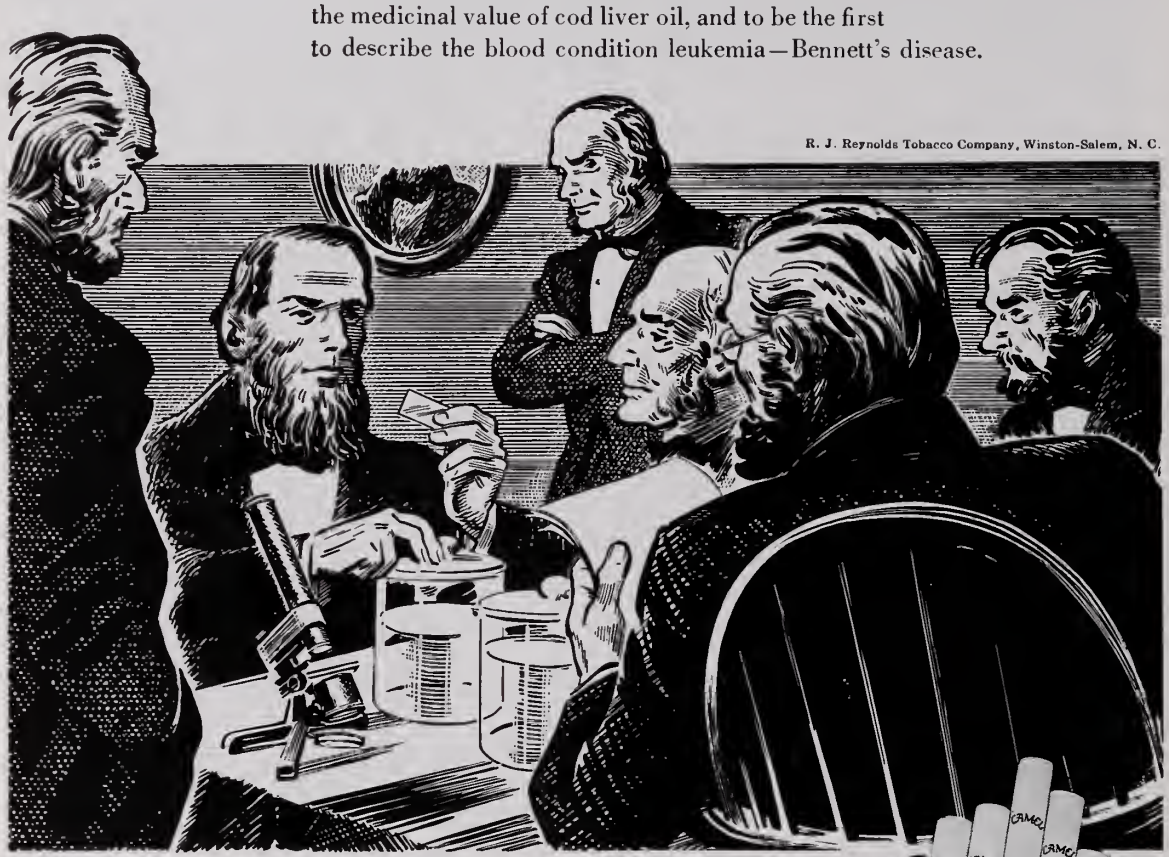
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THE ETIOLOGY AND TREATMENT OF CHRONIC ULCERATIVE COLITIS (NON-SPECIFIC)*

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I AM PLEASED to discuss certain phases of a disease, varied in clinical presentations, fickle in character, one having considerable mortality and apparently on the increase.

It is a disorder affecting principally young people in the formative and creative years of life, and often those with intelligence above the average. It runs a long course with a pronounced tendency to relapse, and despite much patient investigation, and accumulation of knowledge of various aspects of the illness, it still remains obscure in its etiology, uncertain in its course, and fickle in its response to treatment.

As to the etiologies and the suggestions of treatment that have been advanced in later years, the following are the more important and are presented with certain thoughts and deductions of the writer.

Infectious. Much interest has been attached to the diplococcus or diplostreptococcus of Bargen[1] and Bargen and Logan.[2] It is not a highly virulent pathogen but, like many other intestinal organisms, in certain symbiotic combinations, can become parasitic or be important as a secondary invader but it is not the cause of ulcerative colitis. What has been presented concerning this organism is not biologically much different than any of the usual forms of streptococci met with in the bowel of which most forms met with are the more common types of streptococci.

Paulson[3] produced lesions of the colon with B. coli given parentally and Bassler[4] described a highly toxic hemolytic B. coli as important in the disease.

The B. coli are found in the intestines of all mammals. Of the many forms, using Dunham's classification, no one form can be proven to be definitely infective. Yet the high hemolytic character of the B. coli found in ulcerative colitis, as compared to normal or other intestinal states, gives this organism a significance. In the microscopic pathology found in simple chronic toxic gut states the coli hemolyticus is an important etiologic factor when associated with other organisms especially those of the anerobic group. Coliform organisms represent a family of cousins from the innocent B. coli on one end to the highly pathogenic B. typhosus and B. dysentericus on the other. They must be considered as important in preparing the bowel for subsequent tissue breakdown by a secondary infection bringing on degeneration of the mucosal tissues. With other organisms in the mixed infection, their action is lytic, and by constant reinfection of the mucosa from the lymph structures in and surrounding the gut, a vicious circle is brought about. It is this affinity for the lymphatic structures (the solitary glands in the mucosa, the pericolonic glands immediately outside and the mesentric glands) that is the cause of the recurrences which is the way the disease advances.

The B. dysenteria (paradysentery[5,6]) has occasioned much interest as a cause of ulcerative colitis especially since Felsen's work claiming that ten per cent of cases of acute bacillary dysentery result in a condition simulating chronic ulcerative colitis. What has been stated above in connection with B. coli holds true with this organism which is one of the coliform family.

It was reported by Dragstedt, Dock and Kirsner[7] that they found B. necrophorum in seventy per cent of 298 cases of ulcerative colitis. To me it corresponds to the characteristics of a saprophyte, stimulated in the bowel from the ingestion of milk. I doubt it has significance.

continued on next page

* Presented at the 137th Annual Meeting of the Rhode Island Medical Society, at Providence, R. I., May 13, 1948.

Allergy. To Andresen[8] must be given the credit of drawing attention to mucous membrane hypersensitiveness to food causing acute ulcers of the colon. Drawing an analogy, allergy became important in chronic ulcerative colitis, this being especially true since Gray and Walzer's[9] contribution. Sensitiveness to foods is common thoughout human beings. One can agree that a person with ulcerative colitis and also allergic to certain foods would aggravate an infected and inflammed colon by eating those foods. On the other hand, food allergies alone cannot produce the picture of chronic ulcerative colitis.

There have been a number of other causes advanced in late years. To save time I will only go into two, avitaminosis and psychosomatic factors. There is an old rule of medicine that "when there are so many causes advanced for a disease none of them are right."

Vitamins. That deficiencies of vitamin intake can cause one to acquire ulcerative colitis cannot be proven and seemingly is a far call for a cause. Cossidering the subnutrition existent throughout the world, especially in the last few years, practically half the world should have chronic ulcerative colitis. While as a disease it is slightly on the increase, it must be agreed that this has nothing to do with vitamin deficiency. On the other hand, because of the diarrhea, a secondary type of avitaminosis occurs which suggests the use of vitamins in a general nutritional sense.

Psychosomatic Factors. Every physician who has handled enough patients with ulcerative colitis has observed instances in which the onset of symptoms followed an active emotional upset, or a relapse or exacerabation occurred for the same reason. The colon is close to the brain and it is not difficult to understand why a patient whose colon is diseased would be locally disturbed by emotional disturbance. But after all that has been written on the subject, an emotional disturbance per se is not the direct cause of ulcerative colitis.

Wittkower[10] reported that constant apprehension, prolonged tension, infantile reaction to fear, financial or occupational worry, attachment to a parent or a relative, fear of pregnancy, domestic or love difficulties, forthcoming examinations, immature sexual conflicts were more frequent in his patients than in the general population. This is no doubt true but they do not occur more frequently than in patients with other conditions in a gastroenterological practice. This is more obvious in instances of so-called mucus colitis, which is a psychosomatic affair, but not ulcerative colitis. The writer has seen nineteen instances of chronic ulcerative colitis treated totally by psychiatric methods without lasting benefit, and twenty-two more were handled by a physician and psychiatrist together seemingly with only slightly more benefit so far as the bowel was concerned.

It is difficult to accept that chronic ulcerative colitis has emotional features as an important cause even though testimony is slowly accumulating to suggest it. Wittkower[10] came to the startling conclusion that ulcerative colitis was a disease of the mentally ill or maladjusted. In my own observations, emotional upsets may be present in about thirty per cent of the cases and in about 25 per cent of gastroduodenal ulcer. These figures are not convincing from an etilogic point of view. Who has the method and ability to judge degrees of mental adjustments? Who has the method and ability to judge how, and why the colon is picked as the battle ground, or why the stomach, the heart, or the kidneys? As Ginsberg and Ivy[11] state, "If these emotional factors are etiologically concerned in the three diseases, why do they affect the stomach in some persons, cause mucus colitis in others, and in still others, as some believe, cause ulcerative colitis?" The writer believes that emotional states occupy about the same significance as allergic factors, namely to unstabilize an already diseased and degenerated colon.

Different workers have made much of chronic ulcerative colitis being a disease of pleomorphous etiological factors. Along the lines soon to be described its development is simple to understand. The error has been that the colon is easily unstabilized for many reasons, and that when any of these factors bring on symptoms, too high a degree of etiological significance is given to them. They disturb the colon physiology, are functional in nature, and are not etiologic in the proper sense.

In using the term "normal" pertaining to the colon one recognizes the wide scope of individual variation within the meaning of the term, variations that are not known or recognized, usually permitting the pathologic conditions of the colon to be overlooked or be designated as "normal". The recent history of the physiology of the colon has largely been advanced by the development of radiological technique and its application to the alimentary tract. Even the motor functions are still very incompletely understood. The automaticity of the colon is more quickly disturbed than any other organ of the abdomen, and if, as modern psychiatrists believe, we think with the brain and all parts of the body, then the colon can be assailed in its function from both within and from anywhere in the body. We must then acknowledge that unless we have a reasonable degree of knowledge of the functions of the colon and how agents may disturb the physiology, we cannot understand its diseases.

Micropathology of the Colon

Microscopic examination of what grossly ap-

pears to be a normal colon usually presents quite an array of minute pathologies. This statement is based on the many instances at autopsy where colon disease was not believed to be present. In observations made years ago in the New York City morgue, the colons of fifty consecutive autopsies in instances where death was dramatically brought about, there were but nine instances of perfectly normal colons from a microscopic standpoint. The findings were:

1. Detachment and lysis of cells of tubules
2. Destruction of tubes
3. Attached and adherent mucus
4. Degenerated mucosa
5. Submucosal edema
6. Enlarged solitary follicles
7. Interior cells of follicles broken down
8. Thickened peritoneum
9. Degenerated nerve cells
10. Endothelial cells of blood vessels detached
11. Blood vessels denuded of cells
12. Hemorrhagic areas
13. Sclerosed arterioles
14. Thickened and sclerosed venules
15. Phlebitis of venules
16. Cell detritis in submucosa
17. Giant cells free in submucosa
18. Free somatic cells
19. Infiltration cells
20. Fibrils of scar tissue
21. Congestion (enlarged) blood vessels
22. Large single and multinucleated cells
23. Many lymphocytoid cells

Unless what we have believed of cellular pathology since Vichow's time is to be scrapped, it is difficult to understand why minute pathology of the colon should continue to receive no attention.

Biotoxic Intestinal States

The baby is born with a sterile intestinal canal which presents swarms of bacteria a few days after birth. The only cause of digestive disturbances in infancy is dietetic never bacterial. For various reasons the so-called natural immunities against these organisms may not be acquired or acquired to high enough degree and a low grade biotoxic condition develops. The mucosa continuously subjected to this toxicity over years of time brings about the micropathologies mentioned. The resistance to bacterial invasion and lytic agents then being lowered, bacterial infection assaults the mucosa with the production of congestion, inflammation and ulceration. When the colon is breaking down structurally it is not a question of this or that bacteria being present and a significance placed on some one as the cause of the disease. Any one of several bacteria is capable of producing it. In fifty cases of well established ulcerative colitis the significant bacteriologies met with were:

Hemolytic streptococci specified types	42 cases
Green streptococci	21 cases
Nonhemolytic strpetococci	17 cases
Alcaligenes fecaloides	33 cases
Staphylococcus albus	31 cases
Clostridium oedematis maligni	25 cases
Escherichia coli specified types	24 cases
Gram positive enterococcus	22 cases
Pseudomonas aeruginosa	19 cases
Clostridium welchii	7 cases
Erythrobacillus prodigiosa	18 cases

I believe that cases of ulcerative colitis start their development early in life in the following sequence: failure to build up the intestinal immunities required, a series of departures of normal physiology of the colon, a biotoxic gut state causing micropathologies in the colon mucosa, the effects of different agents unstabilizing the bowel, secondary bacterial infection, and reinfection from the lymph strictures.

Matters Pertaining to Classification

The use of the term cure in connection with chronic ulcerative colitis cannot be used. I agree with Kiefer[12] that the term control as good, fair and poor is all that is permissible. By good is meant where both the local and general constitutional symptoms have been absent for three years, the patient being active and capable to stand strains, physical and emotional, eating any foods, no treatment, etc., without ill effect. By fair is meant that marked improvement had taken place, there is practically no disability, with but mild and easily controlled symptoms. Poor are those in whom continuation of symptoms has produced a severe degree of disability or complications.

In the cases treated the results of treatment in my series were good in 54 per cent, in 38 per cent fair, and poor or operated upon in 8 per cent. Even this 8 per cent were a varying lot.

It serves no purpose to classify the cases as left sided, right sided or entire colon, or in duration of the disease or ages of the patients. Of interest here is that the younger the patient the more often the disease is serious and the older the patient the easier it is to control. Also, in the vast majority of the patients the disease begins in the lower left colon and when confined to this area ulcerative colitis is easier to control. The disease should be classified as primarily mucosal or lymphatic. The lymphatic cases are those in which the lymph structures are deeply involved early, and the most difficult to control, and comprise the larger number requiring surgery.

Under proper medical treatment the less severe cases certainly can be gotten in hand easily, practically every one of them. When the profession

continued on next page

meets the responsibility of better diagnosis and treatment of this disease, the instances requiring surgery will be few indeed.

Of those cases with continued diarrhea and pathology, about two-thirds will be due to chronic ulcerative colitis. As the cases are met with, the entire colon will be involved in about half, and the rectum, sigmoid and descending colon in about one-third. In about one-fifth the process stops at the hepataic flexure or is segmental. In those with short histories or very superficial and moderate involvement, the colon may appear normal and rugal studies for diagnosis are necessary. Often a cured case will show a definite change by x-ray. After years of time, a colon may reconstruct itself enough for it to appear quite normal. In the majority of the cases some degree of the pathologic x-ray picture persists, and according to Ricketts, Kirsner and Palmer [13], regression occurs in approximately only ten per cent.

In the past twenty years the writer has seen 542 cases of chronic ulcerative colitis, non-specific in classification. Of these 161 are left out of consideration for various reasons. The remaining 392 cases were under more or less continued observation and had been treated for a sufficient period to drew some deductions. I desire to repeat that one must keep in mind that the disease is so fickle, experience with the cases so variable, and the results from different items of treatment so unpredictable, the status of disease so difficult to classify, that, even more so that in peptic ulcer, statistics are only of relative value.

Treatment

It is well to begin treatment with the patient in bed which is an essential in the febrile and fulminating cases. The principle of rest brings about physiological reconstruction of depleted bodily functions and mental energies. By continued rest and heat to the abdomen a moderate diminution of the hyperactivity of the colon occurs, somewhat limiting cramps and diarrhea and often doing away with opiates and sedatives. If a start in bed is not practical, it is well to cut out all social activities, house responsibilities, encourage resting, and have a happy and pleasant atmosphere around the patient.

This early stage of treatment is the best time to question the patient on any worries, fears and anxieties, emotional conflicts, maladjustments, etc., and exercise common sense, the teaching of the Bible or Talmud to straighten them out. If the patient requires psychoanalytical treatments it is better not to conduct these when the patient is in bed.

Often intravenous therapy is necessary to overcome dehydration, subnutrition and debility. Only blood and plasma are employed since all the others are only poor substitutes. Intravenous mercurochrome may be employed alternating with the blood and plasma. A recurrence is easily brought about by a respiratory infection.

Diet. No restrictions of nutritious foods should be carried out in treating chronic ulcerative colitis. Two fundamental rules are important. 1. The taking of the largest amount of protein foods possible in order to meet the shotages of nutrition caused by the diarrhea, infection, weight loss, anemia, avitamatosis, etc., to which amino-acid and supplemental feedings are added, but milk is not allowed. Sometimes infusions containing amino acids are employed. Effort should be made to keep the serum protein at the highest possible level.

2. The physical character of all foods be fluid or semi-fluid so as to digest the largest amount in the upper levels of the small intestine and so that one has the smallest amount of residue to collect in the colon.

Allergy. In the majority of cases of ulcerative colitis the history of an allergy to certain foods cannot be obtained. Since milk, eggs and wheat comprise about 90 per cent of the food allergies, these are eliminated at the start of treatment. In my experience, antiallergic diets that are difficult to follow (Rowe and Andresen) are rather unsatisfactory, especially in the ambulatory case. However, there is no objection to employing these eliminating types of diet because of the bland, low residue properties which, in my opinion, account for most of the good effects that have been attributed to them.

Vitamins. Moderately large sized doses were used by mouth and parental injections. Natural B. complex and injections of crude liver answer well. Effort should be made in the diet to employ foods high in vitamins, since natural vitamins are of more value than synthetic ones.

Anti-diarrheal measures may be used to control a large number of movements where these are too distressing. One of the opiate preparations is best used occasionally, but, if possible, rest and sedatives should be tried first. During the course of treatment in all cases and for long periods of time, a teaspoonful of bismuth subgallate is given in water before breakfast, (sometimes also at bedtime) and this may slow down the movements. Occasionally intravenous alimentation maintained for several days puts the bowel at rest.

Vaccine. Vaccines, made of any of the coliform organisms have been most successful in my hands.

It has been brought out that the intestinal bacteria are the infective factor. As has also been brought out, the organisms of greater significance

here are those of the coliform types and that this coliform group comprises forms all the way from the innocent B. coli to the pathogenic and specific forms of B. dysenteriae, B. paradysenteriae, B. typhosus.

The first vaccine used was the B. coli from the patient when this was highly hemolytic. If not highly hemolytic a strain from another source was employed. It was found that as good results could be obtained from a polyvalent B. dysentery vaccine of organisms taken from instances of acute and chronic dysentery. Sometimes the patient's hemolytic B. coli are added to the stock strains of the paradysenteriae in half and half quantities.

Mercurochrome. The intravenous use of mercurochrome was first described by Young and Hill.[14] In the next seven years a number of articles on its use in ulcerative colitis were published by Einhorn,[15] Rosser,[16] Smithies,[17] and Rouse,[18] reporting optimistic results. As time went on it proved to be a dangerous drug in the dose employed. No investigative work was done to standardize the dose and estimate the safety of the drug. In 1927 in a case of streptococcus septicemia, and one of brain abscess in which mercurochrome was used, intravenously, the autopsies were interesting in that the interior of the colons were deeply stained and apparently the colon was an important source of its elimination. Other than the kidneys, the other tissues of the body were not stained.

Its early use in ulcerative colitis was to control the infection in the bowel wall. No means had yet become practical for accomplishing this, but what was of interest was its use to help control the reinfection factor that infects the mucosa from the glands and thus causes the recurrences. In the early days the doses of mercurochrome employed was approximately 0.168 gm for a person 50 kilos in weight. My minimum dose is 2 cc of a 1 per cent (0.02 gm) solution and this raised in the absence of reaction to 5 cc (0.05 gm). In the vast majority of my cases mercurochrome intravenously was employed, alternating with 250 cc blood transfusions one each four days. Several thousand injections have been given without one untoward effect.

Drugs. Usually the patients had been taking sulfa drugs in various forms before I saw them. None of these drugs were curative to any dependable degree in the well established case, even admitting that an occasional case would show some benefit for a short spell. It has been reported that after the oral administration of the non-soluble sulfa drugs there is a decrease of the gram negative and an increase in the gram positive organisms which is not so.

Many of the cases have an achylia or low acidity from a granular gastritis which the colonic infection brings about. One cc of dilute hydrochloric acid in four to eight cc of gastron well diluted and sipped after meals often is of benefit.

There is no objection beginning the treatment with a run of the non-toxic antiamebic drugs (vioform, diodoquin). Their use surprisingly often brings about a rapid improvement in the diarrhea. This temporary benefit occurs in about half of the instances of chronic ulcerative colitis.

Anemia. Hypoproteinemia. These were corrected by 250 cc of blood transfusions given every fourth day and kept up for weeks. Even in the presence of only moderate anemia these transfusions were employed, because there are other constituents in blood then hemoglobin and proteins that are helpful.

Psychotherapy. Since the writer believes that emotional disturbances are not fundamental in the production of ulcerative colitis psychiatric treatment is considered as of little importance generally. The average physician should take an interest in the patient's problems, making corrections and giving advice so as to bring about adjustments. When the patient was well enough a few questions were asked at various times on matters of personal faults, domestic, family or financial difficulties, etc., and advice given.

Surgery. Chronic ulcerative colitis is a medical disease and should be treated medically as long as there is any hope for improvement. Recovery is slow and it must be remembered that it is a young person's disease (average 28 years). If you can keep these people living long enough, time will benefit and often cure the disease. There is no disease in medicine in which the patient can reach such a state of emaciation, debility and illness and yet recover. The decision for surgery carries much responsibility and should be made by an experienced person. There also is no disease in which operative statistics vary so markedly. Considering mortality and the unhappiness of an ileostomy or cecostomy, one usually is influenced against operating upon these cases early. There are, however, certain criteria that serve as guides. These may be said to be:

I. Where the disease has existed for a length of time without substantial benefit, and general health is failing in spite of good medical handling and a conscientious patient. Cattell[19] reports that about one-quarter of the cases at the Lahey Clinic are operated upon.

II. Perforation, which occurs very infrequently.

III. A long history of hemorrhaging from the bowel with continued diarrhea.

IV. Internal and multiple external fistulae of the rectum.

continued on next page

V. Strictured state too high for manual divulsion. Those in the rectum usually can be controlled.

VI. Malignant disease.

Cattell[19] stated an ileostomy is not a cure, and it may be asked if the removal of an organ (colon) can be designated as a cure.

Carcinoma in chronic ulcerative colitis is reported from 1.9 to 7 per cent. While carcinoma may develop from the inflammatory pseudopolyps of ulcerative colitis it is rare. In my cases followed over ten years it occurred in three instances (1 per cent). Polyposis accompanying chronic ulcerataive colitis is generally accepted as the designation of a bad case and one in which colectomy is advisable. There were many instances in which the symptoms have abated and the patient got along well even though the polyposis persisted. If fistulae are in the lower rectum and the condition is active, local surgery is not advised without a preliminary colostomy or ileostomy.

The question of surgery should be left quite up to the personal equation of the individual. If the person is reasonably in control of the condition, able to be fairly active up and around, work, etc., I advise conservatism.

There are people who would rather commit suicide than carry an ileostomy, and others who don't mind them at all. Some even are so satisfied that they will not agree to a reconstruction operating making possible the elimination of the ileostomy bag. So the percentage of cases in which major surgery is recommended is variable. In my practice it is about 5 per cent (appendicostomies not included) and usually performed for complications.

I here would like to present the use of appendicostomy (cecostomies) with irrigations. Appendicostomy has been discarded and it should be reestablished and be popular as an addition to the medical handling of chronic ulcerative colitis. An appendicostomy is a very minor surgical operation and can do no harm if it does not good. It is not inconvenient to the patient and when properly performed has no drawbacks connected with it (such as leakage, closure, etc.) What I observe today in handling chronic ulcerative colitis is a relatively poor effort at diagnosis and medical treatment and then a jump to ileostomy, colectomy and perhaps removal of the rectum. What would be better is more assiduous medical attention, and appendicostomy, if after a reasonable time, improvement is not manifest solely on medical treatment, and then finally the major surgery if all else fails. On the whole appendicostomy (cecostomy) has been performed 32 times and only four required more serious surgery after that. It does no harm and one should not be in a hurry to close it. Should further surgery be necessary the small appendicostomy opening would not interfere. After the ileostomy if colonic irigations are introduced from the cecum (by way of appendicostomy or distal stoma of the ileostomy) the number of final ileosigmoidostomies would be increased.

At the A.M.A. meeting of 1947 two opposite points of view were expressed. Bargen was of the opinion that the condition should be judged as a medical one, operations not being in order, and Leahy stated that operations should be performed more often and earlier. My own point of view is that a general statement is not important, and the only thing of value is the wisest judgment in the individual case.

I agree with Bargen and Paulson that intractability depends on the skill and perserverance of the medical advisor and the man managing the disease. When these are satisfactory, ulcerative colitis will be found to be a disease that is curable and controllable to a high percentage by medical means, and cases so handled will leave but few cases for operation.

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BILATERAL NON-SIMULTANEOUS FEMORAL ARTERIAL EMBOLIC OCCLUSION

JESSE P. EDDY, III, M.D., F.A.C.S.
PALMER CONGDON, M.D.

The Auhors. *Jesse P. Eddy, III, M.D., F.A.C.S., of Providence. Senior Assistant Visiting Surgeon and Director, Vascular Clinic, Memorial Hospital, Pawtucket; Assistant Surgeon, Outpatient Department, Rhode Island Hospital.*

Palmer Congdon, M.D., of Providence. Assistant Physician, Outpatient Department, Department of Medicine, Rhode Island Hospital.

THIS CASE is being reported for two reasons. (1) It would appear to be relatively rare. (2) It serves as a vehicle whereby we may reiterate and emphasize some of the known scientific medical facts about peripheral arterial embolism allowing us to explore some of our own experience and possibly to draw conclusions therefrom.

Case Report

Mrs. F. B. aged 79, a white, widowed female, was admitted to the Jane Brown Memorial Hospital on June 18th, 1946. Her chief complaint was gas on the stomach and pressure against her heart. Three years ago she had a thyroidectomy for hyperthyroidism from which she has recovered nicely. During the past few years she has noticed increasing dyspnea on exertion, orthopnea and occasional ankle edema. She has had a dry chronic cough for fifteen years which has occasionally come in spasms. For the past three or four days she has noticed more gas and belching than usual. Yesterday she described the gas as moving up into her chest, and she developed an ache under the sternum with shortness of breath; no radiation of pain. She became nauseated and has vomited twice. Dizziness developed so she found it difficult to get out of bed. Physical examination revealed a few fine rales at both bases. The heart rhythm was grossly irregular with a bigeminal quality, no murmurs, sounds of poor character, no friction rub. Blood pressure 90/50. There was slight distention of the neck veins. The abdomen was softly distended with gas. The liver was palpable one and one-half fingers below the costal margin; no tenderness. There was one plus edema of left ankle. Impression: Coronary occlusion. Electrocardiogram showed a slow auricular fibrillation with a ventricular extrasystole after each normal ventricular complex. An E. K. G. taken three years ago also showed auricular fibrillation.

She was treated with Digitalis, Quinidine, Codeine and nasal oxygen as indicated, and seemed to be doing surprisingly well. Suddenly at 11:30 a.m. June 24, her sixth hospital day, she complained of numbness in her right leg, and this became cyanotic, blotchy and cold. She rang immediately for her nurse who instantly recognized that a serious situation had arisen, and promptly called her physician. He responded within twenty-five minutes and made a diagnosis of acute arterial embolic occlusion to the right lower extremity. Twenty minutes later I saw the patient, and at that time the right leg was cyanotic to the midthigh where a line of demarcation was present. The patient was dyspneic, orthopneic, anxious, getting nasal oxygen. Examination of the good leg revealed strong pulsations of the femoral, popliteal, posterior tibial and dorsalis pedis arteries. Only a very feeble femoral pulsation could be made out in the right or affected extremity. It gave the impression of a transmitted impulse. A presumptive diagnosis of embolic occlusion to the main femoral artery of the right leg at its branching with the profunda was made. As soon as arrangements could be completed, the patient was removed in her bed, still receiving oxygen, to the operating room and transferred to the operating table still in a sitting up position.

Under one percent local novocaine infiltration anesthesia the right femoral artery was exposed. It was without pulsation and in spasm. It was followed upwards to its branching with the profunda where strong visible pulsations could be seen above. Tapes were placed about the artery above and below, and the artery opened longitudinally in its quiet portion. There was slight back bleeding, no bleeding from above. The embolus could be seen by looking up the artery, and an attempt was made to remove it with suction without success. A Binney type gall bladder clamp was then used and the clot pulled out followed by a spurt of blood that went almost across the room. This was controlled by twisting the tape, and the artery was promptly closed using a continuous suture of five zero fine silk. The superficial femoral vein was then exposed and ligated just below its junction with the profunda. Before ligating, it was opened and free bleeding encountered both from above and below. Pulsations were seen to be pres-

continued on next page

ent in the artery, and the leg, immediately following operation, was seen to have lost its cyanotic, mottled appearance. The numbness and pain disappeared immediately, and the patient could again move her leg. A faint pulsation could be made out in the right popliteal artery, no pulsation in dorsalis pedis and posterior tibial arteries.

Anticoagulant therapy was instituted starting with Heparin injected into the artery itself at the completion of the embolectomy. In the days that followed the patient had no more serious difficulty with this leg, and to all intents and purposes it was essentially normal.

On June 26, 1946, four days after the original embolic occlusion, a completely similar accident occurred in the opposite lower extremity. At 7:30 a.m. she suddenly developed numbness, pain and coldness in the left lower extremity, exactly similar to what had happened before in the right. She was seen by her physician within three-quarters of an hour who again promptly made the diagnosis of left femoral embolic occlusion. At 9:15 a.m. the patient was again in the operating room undergoing another embolectomy. A similar situation was encountered, and another large embolus removed. Following closure of the artery and superficial femoral vein interruption, all major arteries of the left leg were found to be pulsating down to and including the posterior tibial and dorsalis pedis arteries. The patient had no further trouble from either leg during the remainder of her course in the hospital.

About a week late she began to have chills and attacks of increasing breathlessness which suggested repeated pulmonary infarction. She expired on the thirty-seventh hospital day. Autopsy revealed generalized arteriosclerosis, coronary thrombosis, myodardial infarction, mural thrombus left ventricle and left auricular appendage and right auricular appendage, pulmonary infarction, septic pulmonary infarction. The lower extermities were normal.

Through the courtesy of Dr. Davis and Dr. Moor, surgical chiefs respectively at the Rhode Island Hospital and Pawtucket Memorial Hospital, I have been privileged to inspect the records on the cases of peripheral embolic arterial occlusion to the extremities in these two institutions. This gives an idea of the rarity of the condition and of the type of results that we have been obtaining in this community. It furthermore is a considerable educational privilege to be able to review records of this sort as one cannot help but gain much valuable knowledge from the lessons to be learned in such a study.

In a ten year period there have been nineteen such cases discharged from the Rhode Island Hospital and eight from the Memorial Hospital. It can be seen that the great bulk of cases are in patients over sixty years of age. (See Figure No. 1)

Figure 1.

Arterial Embolic Occlusion In Extremities

Age distribution
1937-1947

Age	R. I. H.	Mem.
30 to 40	0	1
40 to 50	3	1
50 to 60	3	2
60 to 70	7	3
70 to 80	4	0
Over 80	2	1
Total	19	8

There is a definite preponderance of cases seen in the female sex. This is probably due to the fact that life expectancy is greater in females than it is in males. (See Figure No. 2)

Figure 2.

Arterial Embolic Occlusion In Extremities

Sex

	Female	Male
R. I. Hospital	10	9
Mem. Hospital	5	3
Percentage	55%	44%

The following arteries were involved, and although this series is small, it would appear that the right femoral artery is more prone to such an accident than the other arteries of the body. (See Figure No. 3)

Figure 3.

Arterial Embolic Occlusion In Extremities

Artery Involved

	RIH	Mem
L. Popliteal	5	0
Rt. Popliteal	3	1
L. Femoral	4	1
Rt. Femoral	7	4
L. Brachial	1	0
Rt. Brachial	0	1
Rt. Post. Tibial	1	0
L. Iliac	1	1
L. Radial	1	0
Rt. Radial	1	0
L. Axillary	0	1

More than one artery was involved in five patients at the Rhode Island and one patient at the Memorial. (See Figure No. 4)

Figure 4.

Arterial Embolic Occlusion In Extremities

Pts. with more than one artery involved.

	RIH	Mem.
Cases	5	1
Percentage	26%	13%

Auricular fibrillation was found in a very large percentage of the cases. Coronary thrombosis and rheumatic heart disease was likewise frequently found in association. (See Figure No. 5)

Figure 5.

Arterial Embolic Occlusion In Extremities

Associated Cardiac Conditions

	RIH	Mem
Auricular Fibrill.	17	3
Coronary Thrombo.	5	2
Rheumatic Heart Dis.	0	2

Approximately two-thirds of these patients come to some form of surgery before their discharge from the hospital. This is largely divided into embolectomies and amputations. (See Figure No. 6)

Figure 6.

Arterial Embolic Occlusion In Extremities

Operations

	RIH	Mem	%
Embolectomies	5	2	25
Amputations	6	4	37

Total no. ops. 17

One patient at RIH had a cerebral accident during op. and died next day. One patient at Mem. refused amputation.

Other adjuncts to surgical therapy which have been used in this community are anticoagulant therapy, intermittent venous occlusion or the Pavex boot, sympathetic novocaine blocks, papaverine, ice.

The mortality in these cases is high, eight such patients dying at the Rhode Island Hospital and five at the Memorial. (See Figure No. 7)

Figure 7.

Arterial Embolic Occlusion In Extremities

Mortality

	Deaths	Percentage
RIH	8	42%
Mem.	5	62%

From this study I suggest the following conclusions: 1. Peripheral embolic arterial occlusion is a surgical emergency of the very first order. Time is of the essence, it merits consideration in the same category as internal hemorrhage, acute perforation of an abdominal viscus, a compound fracture. Other examples could be given ad infinitum. Any sudden pain developing in an extremity, regardless of the hour of the day or night, should be promptly seen and diagnosed. Embolectomy, where indicated, should be done under six hours for the best result. Anything over twelve hours invites disaster. Amputation is an operation of the first magnitude in these cases. Embolectomy is a relatively minor procedure, easy of performance in skilled hands, taking little or nothing out of the patient. 2. The diagnosis of these conditions is relatively simple. All one needs to do is to become as acquainted with the femoral, popliteal, posterior tibial and dorsalis pedis pulsations as one is with the radial pulsation. All patients over the age of fifty that are admitted to a hospital should have on the record an indication of what the arterial status is in both lower extremities. It would be a good routine if our nurses were instructed in the taking of a femoral, popliteal, posterior tibial and dorsalis pedis pulsation on all patients so that they would become vascular conscious and promptly recognize changes in the circulation. We, as physicians, should familiarize ourselves with these pulsations in the normal so that we can more readily recognize them in the abnormal. 3. Patients with auricular fibrillation and coronary thrombosis should be particularly suspect of developing this condition, and should be appropriately watched and warned. 4. It is always more desirable to have a normally functioning artery than to have one which is occluded. This means that wherever possible the embolus should be removed. In some instances where vigorous early medical therapy is instituted including anticoagulant therapy, sympathetic blocks, papaverine and so forth, the extremity may be saved, but it is crippled, never again as normal as extremity with anything short of complete restoration of the arterial circulation. Arterial cripples are pathetic subjects always limited in their activities, subject to claudication and pain, and the future threat of gangrene, together with eventual amputation, if not loss of life.

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SURGERY IN GERMANY

The medical teaching mission to Munich, Germany came in contact with three sharply disassociated groups. These were the American Army, the hospitals for displaced persons, and the German civilian hospitals. There really was no striking difference between the latter two. We did our work at the Altersheim Hospital. As the name suggests, it had been an old folks home and it lent itself readily to its new function. It was a large hospital with many hundreds of beds.

Next door to it across the street from where we lived was the 98th General Hospital of the American Army. This was an enormous place ; a pavilion type of construction such as can be seen at the Peter Bent Brigham Hospital in Boston. The staff of this hospital impressed us as being remarkably high in quality. Lieutenant Colonel Preston was Chief of Medicine, Major Westhazen, formerly of the Massachusetts General Hospital, was Chief of Surgery, and Captain Sosman was Pathologist. He is son of the well-known Radiologist of Boston. I took on several different occasions my surgical group to this hospital where we had demonstrations of surgery and anesthesia.

Neither the D. P. nor civilian German hospitals have mechanical apparatus for anesthesia. They use ether, regional, spinal and some intravenous anesthesia. I demonstrated to the class how to make a Miller cone. I still believe that is superior to the open drop method which is in such common use. I saw a number of gastrectomies, appendectomies and thyroidectomies done under local anesthesia. Patients in war torn Europe do not expect their sensibilities to be catered to as is done in America. I think a number of these students were suffering a great deal of discomfort during the operation.

Aseptic technique in Munich struck us as strange. A surgeon never put his gloves on until he had done his injections for local anesthesia. The Sister in charge of instruments frequently did not put her gloves on until the operation was well under way. At the University Hospital all of the surgeons in the operation changed their gloves four times while doing a thyroidectomy. I could not help thinking that the exterior of the gloves could be easily cleansed had they been kept on, while it seemed to me certain that perspiration from the hands must necessarily have got into the operation.

They evidently had great faith in tincture of iodine as they were continually wiping with it such places as the appendix stump, the cut edge of the stomach, etc. I was told in my early days that iodine was to be used only on dry surfaces. However, a lot of aseptic technique seems far from logical. For instance, in the Army Hospital we all had to tie clean cotton cloths over our street shoes before we went into the operation. That is all well enough but I counted at least six of the Army personnel who did not have cotton cloths over their shoes. In our own Altersheim Hospital we always wore caps and gowns in the operating room. At both the University Clinic and at a large orthopedic hospital, a group of us were ushered into the operating room minus caps and gowns.

I was impressed with the fact that German surgeons were proud of their small incisions. I have heard Dr. Lahey quoted to the effect that in his travels about the United States he has noticed that many surgeons have trouble because they do not allow themselves enough room to work comfortably and to see clearly what they are dealing with. Somebody quoted to me in Munich what I suppose is an old aphorism, "the bigger the surgeon the bigger the incision". On an evening early in our stay we showed the class a movie of a thyroidectomy at the Lahey Clinic. Some of the surgeons were critical because the string muscles were clamped and cut. They felt that was brutalizing the tissues. I watched a skillful German surgeon do the same operation without cutting the string muscles, and I thought the pulling and hauling at the attempt to get exposure was more traumatizing; and they didn't get exposure.

Nevertheless, most of the surgeons I watched had great technical skill. I saw a number of gastrectomies done in an hour and a half each. My only criticism was that I think American surgeons are more liberal in the amount of stomach they remove. As I understood that they did not have a good supply of instruments and apparatus, I was interested to see that two different hospitals used the elaborate machine for closing the opening in the stomach with metal clips. On one occasion at least the machine failed. The clips had to be removed and the sewing done by hand.

Our figures show a proportion of something like eight duodenal ulcers to one gastric ulcer. Over there we were told that the propotion was about 50-50. And, in fact, every case of peptic ulcer that I saw operated upon was gastric. However, at least one of these so-called gastric ulcers turned out to be malignant. I know of no vagotomies being done in our neighborhood, but I met a surgeon from Vienna who told me that he had done 125 abdominal vagotomies. They had no apparatus for giving positive pressure anesthesia and hence did no transthoracic operations. This surgeon felt that he was getting excellent results with this operation in case of peptic ulcer.

I was not so much impressed with the traumatic surgery that I saw. In a beautiful orthopedic hospital they were doing a slide bone graft for an ununited fracture of the tibia. As I watched the manipulations I felt that they were not dealing with an un-united fracture. In fact I thought that there was evidence of quite a fair degree of union. What disturbed me in this case was that there were ten of us watching a bone operation and not one of us had a mask on. At our own hospital there were a number of cases that were definitely un-united fractures. They were fixing these by means of a long steel rod driven longitudely along the shaft of the bone through the marrow of both fragments. Of course only time will tell what their results will be, but there seems to me room for much skepticism.

One Munich surgeon is doing a great deal of cineplastic work on amputation stumps. For those of our readers who are more interested in the higher mental realms of medicine rather than the mechanical aspects of surgery, I would explain that this consists in forming skin lined tunnels through the muscles in order that these muscles may be used to manipulate artificial fingers. This work is ingenious and spectacular. How much it adds to the value of prosthetic apparatus for every day work seems problematical.

The thing that surprised me was that they very decidedly were not using early ambulation. I would say in fact that they were keeping their patients in bed much longer that we did ten or fifteen years ago. This probably is due to the poor living conditions which certainly exist in all the camps for displaced persons and probably to a minor extent in most German homes. It must be extremely difficult or often impossible to give reasonable home care to post-operative patients.

Intravenous fluids were used almost not at all. The technique of venepuncture so highly developed in America has been neglected in Europe. However, they did use plasma to a fair extent. This plasma is furnished by the Red Cross. They were not accustomed to using blood transfusions. This may be somewhat due to the fact that people are under nourished and have until recently been somewhat anemic and had no good blood donors. However, I have a suspicion that the struggles for existence has been so bitter that every one per force has had to look out for himself and it has not been possible for them to develop an organized altruism.

Like Dr. Brunschweig who visited Vienna last year, I have felt that on the whole they were getting along better without these aids than probably most of our over enthusiastic therapeutists in this country would think possible.

THE BLUE CROSS — BLUE SHIELD MERGER

As this is written the Blue Cross-Blue Shield Commissions are meeting at French Lick, Indiana, to vote on proposals which include one for the creation of a national voluntary insurance company under their supervision. The proposal was advanced in a 68-page brochure issued by the Commissions to a limited group — the presidents, governing board and executive directors of all Blue Cross and Blue Shield Plans.

Few, if any, county or state medical societies had an opportunity to study the proposal. No copy was sent to any officers of the Rhode Island Medical Society, or to any of the district societies in this State. Perhaps we would be excluded anyway because we have adopted a surgical prepayment plan that is not *exclusively* non-profit in all its ramifications.

The Council on Medical Service of the American Medical Association has issued a lengthy report (which has had the endorsement of the Board of Trustees of the AMA) calling for postponement of the proposition until the House of Delegates can consider it. If this request is not heeded by the administrators of the Blue Cross-Blue Shield Plans, then the entire voluntary movement for health care will be seriously jeopardized.

What is back of this proposal for a national insurance company? Several reasons have been advanced. Some persons charge that a small group of insiders in the voluntary movement are seeking to take over complete control, and these insiders are said to be for the most part non-medical men. The action of the American Medical Care Plans (AMCP), the national organization of Blue Shield programs, in breaking away from the AMA after that body had started it with a $25,000 grant which was repaid this year, is offered as evidence that this theory has some justification.

Doctor Paul R. Hawley, chief officer of the Blue Cross-Blue Shield Commissions, argues that organized labor demands free or subsidized medical care on its terms, and unless its demands are met the present system of medical care will disappear in the maw of a compulsory federal program. A voluntary national insurance company, therefore, would consolidate the programs in all the States, and thereby provide a uniform coverage. But what happens if the single insurance program, which would seek to usurp private insurance in the health and accident field, fails? Would the public discard the entire proposition, or would the federal government move into the picture to replace the voluntary system with a compulsory one? The answer is self-evident.

Organized labor, so-called, will go along with the Blue Cross-Blue Shield Plan for a national voluntary insurance company but it won't compromise on that solution as a final one. Have no doubts about that. Harry Becker, social security director for the United Automobile Workers-CIO, and formerly president of the Group Health Association of Washington, D. C., said after the National Health Assembly this past May that

> "Voluntary plans are good, but by themselves they are not adequate....."
>
> "The Labor and other consumer groups cannot compromise on the basic question: a public program for all of the people....."

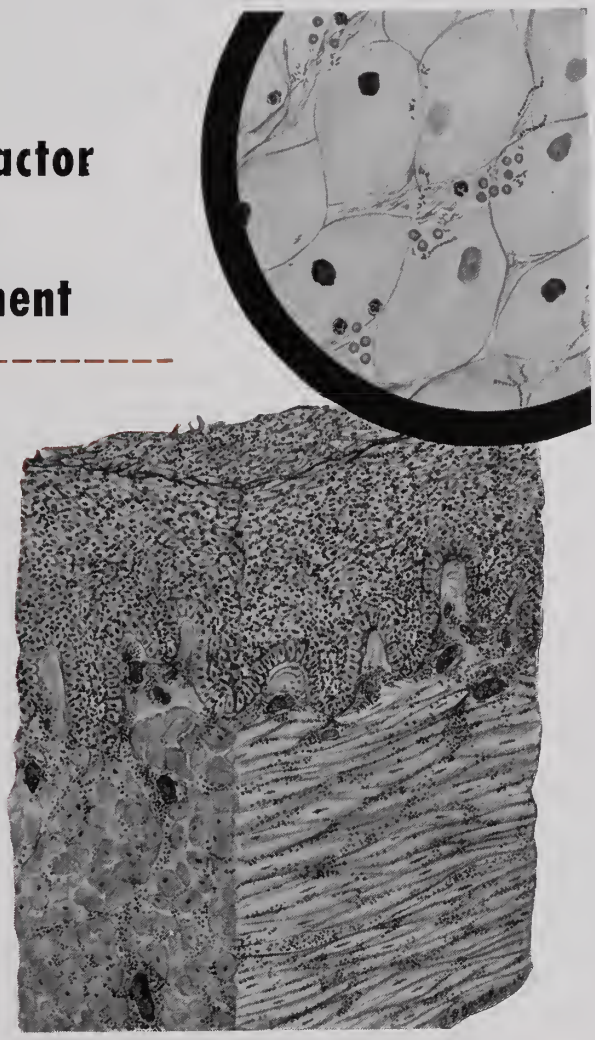
It is true that many of the social security provisions are the result of union contracts. But industry is called upon to pay all or the major portion of the bill.

Becker's own union, the UAW-CIO, has just negotiated a new social security program that provides hospitalization for the worker and his family, income maintenance benefits during periods of lost time for reason of sickness or accident, death benefits, and surgical allowances, *all financed entirely by the employer.* In Rhode Island, industry — not labor — meets nearly all the cost of employee hospitalization provided through Blue Cross, and industry is now accepting the added cost of surgical insurance under our Society's program.

Industry, then, not labor, has the responsibility to provide the adequate coverage it has agreed to pay for, and by whatever insurance program it individually prefers.

Would Doctor Hawley and his Blue Commissions evaluate the future progress of voluntary prepaid health insurance only on the basis of the demands of labor leaders? Has industry, the employee, the medical profession, no rights in the matter?

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

*Boehme, E. J.: S. Clin. North America 25:545 (June) 1945.

DISTRICT MEDICAL SOCIETY MEMBERS

KENT COUNTY MEDICAL SOCIETY

The first Fall meeting of the Kent County Medical Society was held the evening of September 14, 1948, at the Showboat, Tiogue Lake, Rhode Island.

The subject of insurance examinations and current fees for the same, recently endorsed by the Committee on Economics of the State Medical Society was discussed. All members present were agreed that the recently adopted schedule was more adequate and compensible to present day standards. It was moved and accepted that future statements to Insurance Companies re Life, Health or Accident examinations be made as suggested by the Committee on Medical Economics; it was further carried that should any difficulties with this policy arise the same should be reported by the individual physician concerned to the society for appropriate action.

Dr. Vidal, Society President, noted that she had received notification from Mayor Albert P. Ruerat, Warwick, R. I. that a library of several hundred books had been donated the Kent County Memorial Hospital by Dr. Ralph F. P. Lockwood of Warwick. Appreciation of this generous gift was expressed by those present; it was decided that these volumes should remain in the custody of the Warwick Mayor and Board of Trustees until the hospital is erected.

Correspondence re the Catherine A. Miller Trust from the Title Guarantee and Trust Company, New York was brought to the attention of members. It was decided to place this material in the hands of the Corporation Attorney, George Roche.

Following suggestions of the State Medical Group formation of a Public Relations Committee by the Kent County Society was discussed. The usefulness of such a committee being recognized, it was agreed by motion and endorsement that the present executive also function as Public Relations representative.

Dr. Edmund T. Hackman, Warwick Health Officer, commented on the city wide chest survey now being undertaken in that area. A motion was made by Dr. Rocco Abbate that this Society commend and endorse the Warwick Health Department's efforts in this community project.

Dr. Arthur E. Hardy requested preparation for discussion at the next meeting, the clarification of direct and associate memberships in the Kent County Medical Society.

Dr. Charles Ashworth, Department of Surgery, Rhode Island Hospital, gave the evening's address. His topic, CARCINOMA OF THE STOMACH, extremely appropriate currently, was very ably handled and held everyone with considerable interest.

The meeting was brought to adjournment at 11 p.m.

Respectfully submitted,

F. D. Lamb, M.D., *Secretary*

* * * *

The October meeting of the Kent County Medical Society was held at the Frog Farm, Warwick, Rhode Island, Tuesday, October 19, 1948.

This was the first combined meeting of physicians and dentists of Kent County. It is intended that such a gathering shall be held annually, primarily for the discussion and solution of mutual problems.

Dr. Vidal, Society president, called the meeting to order at 9:30 p.m. The question of associate membership in this Society was again considered and final settlement shall be effected at the next meeting.

The purpose and function of Medical Public Relations Committees was outlined by Dr. Vidal. Particular emphasis was placed upon cooperating to the greatest possible degree with a local and favorably-inclined press.

Request to provide a medical speaker for the coming senior assembly at West Warwick High School was made by the school principal. Dr. Peter Erinakes accepted this assignment.

Dr. Vincent Ryan, dermatologist from Providence was the evening speaker. He very ably presented a discussion of "Lesions of the Oral Mucous Membranes".

The meeting adjourned at 11:30 p.m.

Respectfully submitted,

Francis D. Lamb, M.D., *Secretary*

NEWPORT COUNTY MEDICAL SOCIETY

The Fall meeting of the Newport County Medical Society was held at the Newport Hospital on Tuesday evening, September 28, 1948 with nineteen members attending.

continued on page 678

A TOP FAVORITE IN PROTEIN SUPPLEMENTATION

Caminoids

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BRAND OF AMINOPEPTODRATE

For Oral Administration

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

IN NEW PACKAGE SIZES for GREATER CONVENIENCE and ECONOMY



Caminoids* is now supplied in cans containing 1 pound and 5 pounds, as well as in bottles containing 6 ounces. **CAMINOIDS** is derived by enzymic digestion of liver, beef muscle, wheat, soya, yeast, casein, and lactalbumin. It has high biological value, high palatability, and outstanding patient-acceptance.

DOSAGE: One tablespoonful of **CAMINOIDS** three times daily supplies 12 Gm. of protein as hydrolysate. Available at leading pharmacies.

*New designation of Aminoids adopted as a condition of acceptance by the Council on Pharmacy and Chemistry of the American Medical Association. The word CAMINOIDS is an exclusive trademark of The Arlington Chemical Co.

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NEWPORT COUNTY SOCIETY

continued from page 676

Dr. Philomen P. Ciarla, President, called the meeting to order at 9:05 p.m.

Mr. Lawton from the New England Telephone and Telegraph Company explained the function, installation, and costs of a Doctors' Exchange switch board stating that a 20 plug board could be installed and ready in about six months at a cost of $23.00 per month for the board and $3.00 per month charge for each doctor's line attached to the board.

Old Business: Dr. Samuel Adelson reported that the Annual Meeting of the Rhode Island Medical Society will not be held here in Newport next year because the building facilities here are not adequate for such a meeting. Dr. Adelson suggested that Dr. Michael Sullivan be recommended to the State Society for the General Practitioners' Award. Dr. Louis Burns nominated Dr. Sullivan and this was seconded by Dr. John Malone. Dr. Adelson was appointed a committee of one to submit material on Dr. Sullivan to the State Society.

New Business: Dr. Frank Logler moved that the County Society approve to cooperate with the National Red Cross in its program to set up Blood banks and moved that a committee be appointed to work with the Red Cross if and when the opportunity arises to have a blood program in this locality. The motion was seconded and approved. Dr. George Eckert was made chariman of this committee — other members were Drs. Norbert Zielinski, Burns, Logler, and Mayner.

Our guest speaker, Dr. Jesse P. Eddy, 3rd, of Providence, gave a very instructive talk entitled "Sympathectomy and its Role in the Treatment of Vascular Disease." This lecture was illustrated by lantern slides. A patient with severe Buergers Disease was presented. Dr. Eddy had recently sympathectomized all extremities of this patient with the result that the patient was completely relieved of symptoms and showed almost complete healing of his fingers and toes which previously were gangrenous.

The meeting adjourned at 10:50 p.m. Collation served.

Respectfully submitted,

JOHN M. MALONE, M.D., *Secretary*

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PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was called to order by the President, Dr. Earl Mara, at noon, September 23, 1948 in the Nurses Auditorium of Memorial Hospital.

It was moved by Dr. Duncan Ferguson that the committee which wrote the articles in rebuttal to the series in the Providence Evening Bulletin concerning Medical Care be commended and that the secretary make appropriate mention in the records. This motion was passed.

The following physicians were elected to membership in the Association:

Dr. Robert Clement Hayes
Dr. Alice Madros Kechijian Bandeian
Dr. Edward Damarjian — Associate membership

Dr. Charles Farrell discussed a radio program arranged by the Public Relations Committee of the Rhode Island Medical Society and by a majority vote it was decided that the Pawtucket Medical Association would sponsor this program through local stations.

A film, "The Treatment of Trichmonas Infection," was then presented, at the conclusion of which the meeting was adjourned.

Twenty-three members attended.

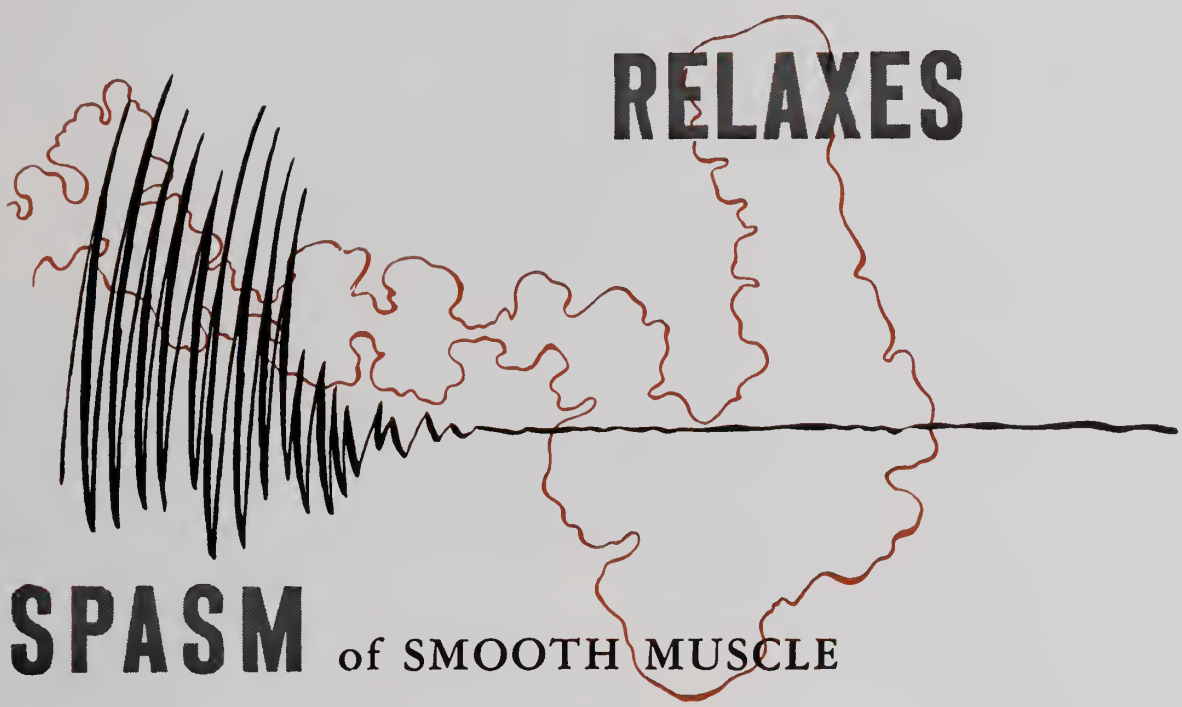
PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, October 4, 1948.

Prior to the meeting Dr. Philip Batchelder, President of the Association, presided with Dr. Joseph C. O'Connell, President of the Rhode Island Medical Society, at exercises held in the

continued on page 680

TRASENTINE-PHENOBARBITAL



Trasentine acts selectively on the smooth muscle "receptive substance" associated with parasympathetic nerve endings in the abdominal viscera—a fact that explains the relative absence of those side effects so often produced by atropine or belladonna. The neuro-musculotropic action of Trasentine is enhanced by the mild sedative effect of phenobarbital.

Trasentine-Phenobarbital tablets contain Trasentine 50 mg. with phenobarbital 20 mg.

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lower hall and reading room for the dedication of a memorial tablet erected by the Rhode Island Medical Society in memory of four members who died while in the service of the armed forces during World War II.

The regular meeting of the Association was called to order by the President at 8:50 p.m. in the Library auditorium. The reading of the minutes of the previous meeting was omitted by general consent.

The Secretary read a communication from the Secretary of the Rhode Island Medical Society, noting in particular the following items:

The Cancer Committee of the State Society, with cooperation from the Rhode Island Cancer Society and the State Department of Health, will hold an all day Cancer Conference for physicans at the Medical Library on Wednesday, November 17, 1948.

The Committee on Medical Defense asks that each district society again call to the attention of its members the importance of having liability insurance as a protection in threatened malpractice suits. Complete information on such insurance can be secured by communicating with the Executive Office.

The House of Delegates has voted to hold the annual meeting of the Society in 1949 at the Medical Library in Providence, on Wednesday, May 11, and Thursday, May 12. Members are asked to check these days far in advance in order to keep them free to allow attendance at the 138th Annual Assembly of the Society.

At a meeting of the House of Delegates on September 29th a budget almost indentical to that for the current year was approved for the continued operation of the Society and the Library during 1949. At the same time the House of Delegates set as the dues for 1949 for Fellows in practice more than one year, $40 payable quarterly if a Fellow so desires, and for Fellows in their first year of practice, $25.

After a report by Dr. Joseph O'Connell, president of the Society, relative to his visit to Washington during the summer to discuss the problem of staffing the Veterans Hospital at Providence with U. S. Veterans Administration and a Congressional group, the House of Delegates unanimously adopted a resolution for transmission to the Veterans Administration.

The House of Delegates has voted that every Fellow of the Society shall receive a letter restating the previous action of the House relative to fees for physical examinations for insurance companies, and calling attention to the fact that this action is official action by the Society which should be respected by every Fellow until such time as the action is altered or rescinded.

The Secretary reported for the Executive Committee as follows: The Executive Committee agreed that if the Rhode Island Medical Society should arrange to have a mid-winter meeting outside the City of Providence, and a joint meeting with this Association as has been the policy in recent years, that the regular February meeting of the Association would be held on whatever date is determined for the joint meeting by the State Society.

The Executive Committee authorized the President of the Association to appoint a committee to re-open the study relative to a central telephone exchange under the control of the Association.

The President announced as follows: That the Annual Dinner and Golf Tournament of the Association would be held at the Agawam Hunt Club on Wednesday, October 20 and that a splendid program was being arranged by the Chairman of the Committee, Dr. Herman P. Grossman.

That the obituary committee of Dr. Albert H. Miller and Dr. Robert H. Whitmarsh has prepared and has submitted for the Association's records a tribute to the late Dr. John A. Hayward.

That to fill vacancies on the Executive Committee of the Association he had named Dr. Alfred L. Potter, Dr. Louis Kramer, and Dr. E. Victor Conrad to the Committee; and he had also named Drs. Potter and Conrad as Delegates to the House of Delegates of Rhode Island Medical Society to fill vacancies to that body from this Association.

continued on page 683

P M A GOLF WINNERS

The annual dinner and golf tournament of the Providence Medical Association was held at the Agawam Hunt Club, Rumford, on October 20. Winner of the President's trophy, awarded by Dr. Philip Batchelder, was Dr. W. J. H. Fischer who scored the low gross of 77.

Other winners were: 2nd low gross, Dr. Frank Cutts (84); low net, tie between Dr. Clarence J. Riley and Dr. Benedict Chapas, each of whom scored 68; second low net, tie between Dr. Clifton B. Leech and Dr. Robert Riemer, both of whom turned in 69's; guest prize, low gross, to H. French (87), and low net, Dr. Kenneth T. Moore, (69) formerly of Providence and now a resident of Hanover, Mass.

Ninety members of the Association and guests attended the dinner in the evening. A program of entertainment was provided by the committee of the Association headed by Dr. Herman P. Grossman.

The newest giant stride in penicillin therapy . . .

DEPO*/penicillin

MAINTAINS THERAPEUTICALLY EFFECTIVE BLOOD LEVELS FOR 96 HOURS IN THE MAJORITY OF PATIENTS

Upjohn is privileged to announce the newest in the series of giant strides in penicillin therapy—DEPO-PENICILLIN—96-hour therapeutically effective blood levels made possible with a single injection of Upjohn's uniquely prepared Crystalline Procaine Penicillin G suspended in Peanut Oil containing 2% W/V Aluminum Monostearate. The Upjohn process of suspending smaller than micra particles of Crystalline Procaine Penicillin G in Peanut Oil gelled with a dispersing agent also affords a free-flowing preparation which may be kept at room temperature and administered intramuscularly with syringe and needle which do not have to be free from moisture. DEPO-PENICILLIN is recommended for use in all those conditions in which other forms of repository penicillin have been indicated.

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Want a potent multivitamin preparation that looks, smells and tastes good? Have you tried the honey colored liquid preparation with the citrus-like flavor and odor? It's Vi-Daylin, Abbott's homogenized mixture of vitamins A, D, B_1, B_2, C and Nicotinamide. It pleases the most fastidious patient.

Taken from the spoon or easily mixed with cereal, milk or juices, one small daily dose of Vi-Daylin provides the high concentration of vitamins necessary to meet the nutritional requirements of infants and children. Finicky oldsters find that the slightly larger dose they require goes down very pleasantly.

Vi-Daylin is stable at room temperature, has no fishy odor. At pharmacies everywhere—in bottles of 90 cc., 8 fluidounces and 1 pint. ABBOTT LABORATORIES, North Chicago, Illinois.

Each 5-cc. teaspoonful of Vi-Daylin contains:
Vitamin A.....3000 units
Vitamin D.....800 units
Thiamine Hydrochloride.... 1.5 mg.
Riboflavin.....1.2 mg.
Ascorbic Acid.....40 mg.
Nicotinamide.....10 mg.
Contains not more than 0.5 percent alcohol

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(VITAMINS A, D, B_1, B_2, C AND NICOTINAMIDE IN LIQUID FORM)

PROVIDENCE MEDICAL ASSOCIATION

continued from page 680

Dr. Daniel V. Troppoli reported that the Executive Committee recommended for election to active membership in the Association the following:

Walter E. Campbell, M.D., Earle F. Cohen, M.D., Henry B. Fletcher, M.D., Frank Giunta, M.D., James F. Hardiman, M.D., Alfred Kant, M.D., John Roque, M.D., Milton G. Ross, M.D., George H. Taft, M.D.

The motion was made, seconded and unanimously adopted that these physicians be elected to active membership in the Providence Medical Association.

Dr. Batchelder stated that Dr. James J. Scanlan, an intern at St. Joseph's Hospital, has submitted a case report for competition in the Association's Prize Case Report Contest and that he would now present the case to the Association. Dr. Scanlan presented a case on "MYXEDEMA AND PSYCHOSIS".

Myxedema is due to endocrine dysfunction and is amenable to cure. Symptoms of asthenia and lethargy set in followed by puffiness and inability to concentrate on figures while at work.

In his case these symptoms were followed by hallucinations of persecution and delirium. She has typical facies, low metabolism, and a cholesterel of 240. On treatment with thyroid extract, patient's condition returned to normal and psychosis disappeared.

The president introduced Dr. Robert W. Riemer, Surgical Resident at R. I. Hospital who discussed: "UTERINE APOPLEXY WITH RENAL INSUFFICIENCY". The discussants were Drs. Landsteiner and DiLeone.

Dr. Riemer presented three cases of uterine bleeding with renal insufficiency. Acute renal insufficiency following shock is frequently seen especially during the War. This renal insufficiency was first described by the British in 1941 as seen in the crush syndrone.

The same condition is seen in burns, hemolytic reactions, sulfa intoxications, and they all have the common feature of destruction of tissue. Following shock a period of oliguria and anuria sets in which if prolonged may result in death. Pathologically, we find large pale swollen kidneys. The damage is tubular with no disturbance of the glomeruli or the proximal tubules.

Thirty-six to seventy-two hours after injury, we get precipitation of pigment in the distal convoluted tubules and in the collecting tubules. The term lower nephron nephrosis is applied to this condition.

These patients developed oliguria, hemoglobinemia, and azotemia. Mallory showed that hemoconcentration by hematocrit sets in before clinical finding show up.

During the oliguric stage, patient is treated by limitation of fluids to 1000 cc D/W. After the diuresis sets in, saline is given. Careful check of blood chlorides is done. It is in this phase that a lot of salt is lost in the urine and patients die if saline is not given. One case was also treated with continuous spinal anaesthesia. What effect this had was hard to evaluate since Luke showed that spontaneous diuresis occurs in the seventh to the tenth day anyway.

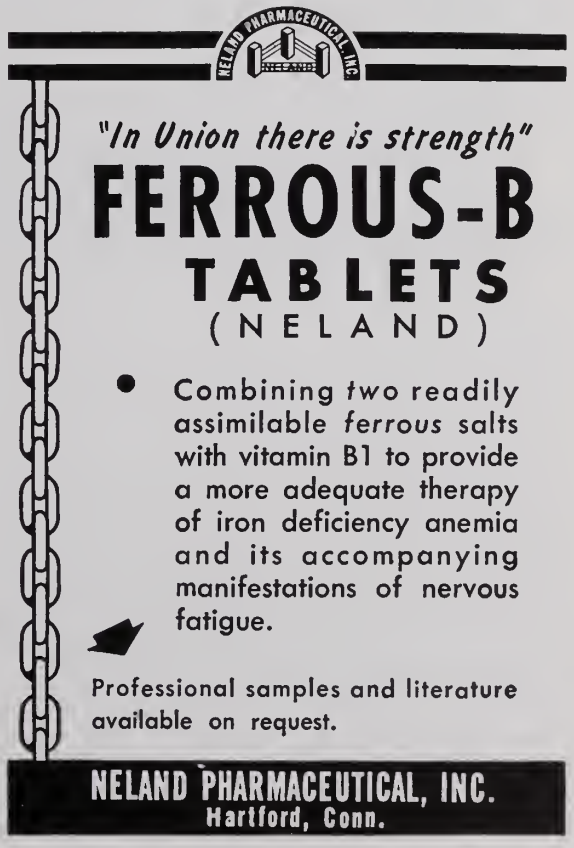
Dr. Landsteiner in discussing the paper stressed the loss of salt through diminished intake, loss through gastric juices, and by increased plasma volume diluting the chlorides. He also stated that acidosis sets in.

In treating the oliguric phase, in addition to fluid and salt restriction, he advised small quantities of blood, amphojel to combat high phosphate level, and continuous gastric lavage.

Dr. DiLeone in the discussion stressed the similarity of the crush syndrone to partial separation of the placenta. He stated that renal insufficiency can also occur in prolonged labor.

The final presentation of the evening was by Dr. Stanley A. Wilson, Roentgenologist at the Salem (Massachusetts) Hospital, who spoke on "PULMONARY CHANGES OCCURRING IN BERYLLIUM WORKERS". The discussant was Dr. Ham.

continued on page 699



THROUGH . . .  the Microscope

Cash Sickness Compensation Now that the elections are over, and the legislators are assured of their offices for two years at least, you may look for the introduction of much legislation in the coming year, and then possibly a retrenchment in the policy the second year as the controversial issues at the state level are avoided. One phase of legislation that will probably come in for plenty of discussion in the next year will be that of cash sickness compensation acts.

Three states, Rhode Island, California, and New Jersey, now have such programs, with Rhode Island's the only one that is a state monopoly. The others allow competition by insurance companies against the plan offered by the State. Perhaps Rhode Island should give some thought to such an approach, rather than take the attitude that its program is letter perfect. Patching it here and there to meet annual criticisms doesn't seem to improve the plan any.

* * *

Where Does GP End? In August the district court in the State of California handed down a decision on a malpractice case which promises to evoke a great deal of discussion in medical circles. The ruling was, in effect, that a general practitioner in a locality where there are medical specialists is legally liable if he, lacking the skill and learning of the specialist, undertakes a specialized procedure.

The case had its start when a physician in Lodi (Cal.) engaged in general practice undertook the treatment of a 62 year old male who had been injured in an accident in which he sustained a double comminuted fracture of the lower left leg, one of the fractures being compounded. The hospitalized patient was treated by a physician who, after x-rays, etc., decided against the use of any traction on the leg.

The patient sued the physician, testifying that because of atrophy of the muscles of the leg (Causing it to be shortened 1¼"), and the pain therefrom, he could not place his weight on the leg and required the use of a cane. The defense contended, among other things, that a doctor practising in a city contiguous to a metropolitan area may testify to the standard of care in a city likewise contiguous to the same area, but that where the issue is the standard of care in a rural community a doctor may testify only if he has knowledge of the standard of care in the particular rural community involved.

The court turned down this argument, maintaining that there might have been a proper distinction at one time, there was no longer any basis for such a rule because of rapid transportation and communication. (The nearest orthopedic specialists available in this instance were 12 miles away.)

The court commented that the record showed the general practitioner was confronted with a very unusual situation and there was no emergency, and he undertook to treat a very complicated, difficult and unusual fracture. The court held that in such a case the general practitioner would be negligent if he undertook the treatment, except in an emergency when no more highly skilled physician was available, or unless he disclosed the need of such ability and his lack of it to his patient and the patient nevertheless insisted upon his proceeding. It stated that the general practitioner, and not his patient, is in a better position to know when the specialist is needed.

* * *

Dates to Check Now The House of Delegates of the Rhode Island Medical Society has set Wednesday, May 11, and Thursday, May 12, for the 138 Annual Meeting of the Society at Providence in 1949. The American College of Physicians will conduct its 30th annual session at New York City, March 28 through April 1, 1949.

* * *

A Sea of Red Ink Under this caption *Philadelphia Medicine,* bulletin of the County Medical Society, sounds a warning about hospital deficits. Stating that this year voluntary hospitals

continued on page 686

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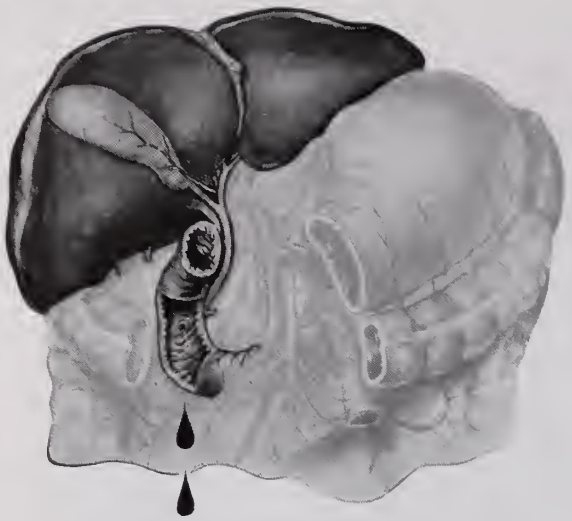
These new Sharp & Dohme preparations provide sulfamerazine and sulfadiazine, in pleasantly flavored, easily administered 10% suspensions. The drugs are evenly dispersed in a very fine state of subdivision and are, therefore, rapidly absorbed.

Used Separately, CREMOMERAZINE and CREMODIAZINE are therapeutically equivalent, but the total dose of CREMOMERAZINE is only one-half that of CREMODIAZINE. Moreover, the dose interval of CREMOMERAZINE (8 hours) is twice that of CREMODIAZINE, a distinct advantage when the patient must not be disturbed.

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*Albrecht, F. K.: Modern Management in Clinical Medicine, Baltimore, The Williams and Wilkins Co., 1946, p. 170.

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THROUGH THE MICROSCOPE

concluded from page 684

in the five-county Philadelphia area will close their annual fiscal accounts with more than $2-million written in red ink, the journal warns that if such deficits continue ultimate bankruptcy lies ahead because the potential contributor is reluctant to help wipe out a deficit unless he has reason to believe the situation will not happen again. As a warning to hospital adminstrators the journal advises that "before appealing to every possible source of increased revenue, administrators of every hospital would do well to make a detailed and earnest study to eliminate any waste, duplication or inefficiency — an efficiency study such as most large businesses conduct from time to time to keep production costs at a minimum."

* * *

The Supply of Dentists The American Dental Association announced last May that the number of dentists in the United States had increased more than 8,000 since 1940 to a total of 78,490. The breakdown by regions showed in the 1948 survey that there was a dentist for every 1,817 of population in the country; one for every 1,655 in New England; and one for every 1,686 in Rhode Island.

The supply of new dentists, however, from the nation's 39 accredited dental schools reached a new post-war low this year with only 1,713 graduates. And next year the number of graduates will reach a ten-year low of less than 1,500, far below the anticipated loss of approximately 2,000 dentists annually through death and retirement. The upswing will start in 1950 as the large World War II veteran classes begin to complete their postgraduate studies.

* * *

New OB-GYN Board Rulings The American Board of Obstetrics and Gynecology has announced a number of changes in its requirements and regulations. Foremost among the new regulations are those that (1) defines adequate training as meaning a minimum of 6 months, full-time, in the branch of either obstetrics or gynecology relegated to a minor role in a candidate's training and preference for practice; (2) defines acceptable preceptorship training; (3) extends present regulation of at least 6 months of practice in the specialty following the completion of an acceptable training period, to a requirement of 2 years post-training practice limited to the specialty; (4) outlines specific requirements for approval of hospital services for residency training; (5) effective immediately, eliminates temporary approvals of hospital services for residency training.

Orapen-250

It is now possible to give 250,000 units of crystalline penicillin G (potassium salt) in one coated, pleasant-tasting, buffered tablet, if you specify the Schenley product. Ample evidence supports the value of the oral administration of penicillin when given in sufficiently high dosage. Clinical reports show that even serious infections due to penicillin-sensitive organisms—such as acute respiratory illness,[1,2,3,4] impetigo,[4] gonorrhea,[5] and rheumatic fever (prophylaxis)[6]—can be treated effectively by this convenient, painless method of administration.

ORAPEN IS UNIQUE
A special coating completely masks the taste of penicillin. ORAPEN is stable at ordinary room temperatures, eliminating necessity for refrigeration.

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5. New York State J. Med. 48:517 (1948).
6. Lancet 1:255 (1947).

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Orapen-100 · Orapen-50
[PENICILLIN TABLETS SCHENLEY]
Each containing 250,000, 100,000, or 50,000 units of Penicillin Crystalline G.

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ORAPEN-100:
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HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY

Report of Meeting Held on September 29, 1948

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, September 29, 1948. The meeting was called to order at 8:35 p.m. by President Joseph C. O'Connell, M.D. The following Delegates were in attendance,

Officers of Rhode Island Medical Society:
Joseph C. O'Connell, M.D.
Edgar S. Potter, M.D.
Morgan Cutts, M.D.
Charles J. Ashworth, M.D.

Providence Medical Association:
Philip Batchelder, M.D.
J. Murray Beardsley, M.D.
E. Victor Conrad, M.D.
Frank B. Cutts, M.D.
Donald DeNyse, M.D.
David Freedman, M.D.
Russell R. Hunt, M.D.
Albert H. Jackvony, M.D.
Walter S. Jones, M.D.
Herman A. Lawson, M.D.
Edward A. McLaughlin, M.D.
Michael J. O'Connor, M.D.
Daniel V. Troppoli, M.D.
George W. Waterman, M.D.
Frederick A. Webster, M.D.

Washington County:
Julianna R. Tatum, M.D.

Kent County:
Rocco Abbate, M.D.

Newport County:
Louis E. Burns, M.D.

Pawtucket Medical:
Charles L. Farrell, M.D.
Earl J. Mara, M.D.
Louis I. Kramer, M.D.

Also in attendance was Mr. John E. Farrell, Executive Secretary.

REPORT OF THE SECRETARY

Dr. Morgan Cutts, Secretary of the Society, reported as follows:

Since the last meeting of the House of Delegates the Council of the Society has held two meetings to complete the business problems of the Society. A brief summary of the actions taken in major matters is as follows:

War Memorial

The design, purchase and erection of a memorial tablet for the Medical Library to the memory of the four Fellows who died during World War II while on active service was authorized to the Board of Trustees. This tablet has been erected in the lower hall of the Library.

Building Repairs

It was necessary to have the roof ventilators replaced this summer, and the Board of Trustees was authorized to make the expenditure for this work at a cost of $800.

The Editor of the Journal

In the absence from this country of Dr. Peter Pineo Chase, editor-in-chief of the Journal, the Council authorized the appointment of Dr. John E. Donley, associate editor, as acting editor-in-chief.

Annual Meeting Site for 1949

Members of the Council together with the Chairman of the Committee on Arrangements for the Annual Assembly inspected proposed sites in Newport, R. I. for the 1949 meeting in accordance with instructions from the House of Delegates. A recommendation relative to the meeting for 1949 has been adopted by the Council for presentation to the House.

Invitation to Quonset

An invitation from the Commander of the Quonset Air Station to the President and certain other members of the Society to visit the Station and inspect its hospital and medical facilities, and possibly to hold an assembly there, has resulted in the proposal that possibly the mid-winter meeting of the Society might be held at Quonset. This matter is under consideration at this time.

A M A General Practioner Award

The A M A has revised its procedure for the Award of the medal to the outstanding General

continued on page 690



consistency in therapy of the menopause

PROGYNON-B* injectable form of the primary follicular hormone, meets the requirements of menopausal management: even, sustained estrogenic action—without the euphoristic peaks or valleys of depression that may occur with the more rapidly excreted secondary materials or synthetic estrogens. For example,

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in only one-third the dose of estrone controls menopausal symptoms for twice the period of time.[1] PROGYNON-B contributes still further to the patient's comfort in that it is nontoxic even "in extremely high single and accumulative dosage."[2] Rather, the effect of PROGYNON-B is one of a sense of well-being, as might be anticipated from "the most potent of the natural estrogens."[3]

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PROGYNON-B (Estradiol Benzoate U.S.P. XIII), in oil, ampuls of 1 cc. containing: 0.16, 0.33, 1.0 or 1.66 mg. (1000, 2000, 6000 or 10,000 R.U.); boxes of 3, 6, 50 and 100 ampuls. Multiple dose vials of 10 cc. containing 0.16, 0.33 or 3.33 mg. (1000, 2000 or 20,000 R.U.) per cc.; boxes of 1 and 6 vials.

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(3) Grollman, A.: Essentials of Endocrinology, ed. 2, Philadelphia, J. B. Lippincott Company, 1947, p. 574.

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HOUSE OF DELEGATES

continued from page 688

Practitioner as voted by the A M A House of Delegates at its interim session. Hereafter the county societies will submit their candidates to the State Society which will in turn select one representative from the State to be submitted to the A M A. The secretaries of the District Medical Societies in Rhode Island have been informed of this procedure. To pass on any candidate submitted the Council has authorized the President to name a Committee on the General Practitioner Award, to consist of Drs. John F. Kenney, Isaac Gerber, and Elihu S. Wing.

Woman's Auxiliary

A resolution adopted by the A M A House of Delegates urging that State medical societies consider including in their budget the annual national and state society dues so that the wife of each physician might automatically become a member of the Auxiliary, was tabled. It was felt that the Auxiliary should be allowed to run its organization as it deems best.

Emergency Medical Service

The Council has authorized the President of the Society to appoint a committee on Emergency Medical Service to be prepared to meet any program for a national disaster.

Public Relations

The Council has approved of two recommendations from the Committee on Public Policy and Relations. Authorization was given for the chairman of the committee to represent the Society, at its expense, at the national conference on public relations to be held prior to the start of the interim session of the A M A in St. Louis, on November 27.

Secondly, the Council voted to authorize the payment of $78 for the 26 week broadcast of DOCTOR'S ORDERS under the sponsorship of the Society, with the Committee on Public Policy and Relations authorized to handle the program and prepare the spot announcements that will replace the 'commercial announcement' previously included in the program. Approval was also given to allow any district society interested in sponsoring the program in its area to do so, provided it assumes all responsibility for the details of presentation, and the cost.

Society's Budget for 1949

A proposed budget for 1949, almost identical to that of the current year, as presented by the Treasurer, has been approved by the Council. A recommendation relative to this budget, and the dues assessment for 1949 was adopted for presentation to the House of Delegates.

Use of Building by State Cancer Division

A request for possible use of the basement of the medical library building for the temporary housing of the cancer division of the state health department was referred to the Board of Trustees who were empowered to act in the matter.

State Cancer Conference

Approval was given the one day state cancer conference planned by the Cancer Committee of the Society in cooperation with the state cancer society and the State department of health, and the Council authorized the Treasurer to pay the travel expense of out-of-state speakers invited to address the conference.

It was moved and voted that the report be accepted and placed on file.

COMMUNICATIONS

The Secretary reported receipt of a communication from the President of the Providence Medical Association notifying him that Dr. Alfred L. Potter and Dr. E. Victor Conrad had been named as Delegates from the Providence Medical Association to fill the unexpired terms of the late Dr. Patrick I. O'Rourke and the late Dr. Guy W. Wells.

RECOMMENDATIONS FROM THE COUNCIL

The Secretary reported that the Council of the Society presented the following recommendations to the House of Delegates:

The Council, upon hearing the report of the President of his meeting in Washington, D. C., with representatives of Congress and the Veterans Administration, endorsed the action taken by him as the Society's representative, and voted to refer the Providence Veterans Hospital problem to the House of Delegates for its consideration at the September meeting.

* * *

The Council, upon viewing the detailed report of the Treasurer relative to the anticipated expenses for the operation and the maintenance of the Society during 1949, voted to:

A. Approve the budget submitted by the Treasurer for 1949, and to recommend its adoption by the House of Delegates; and

B. To recommend that the annual assessments for 1949 shall be $40 for Fellows in practice more than one year, and $25 for Fellows in their first year of practice in Rhode Island.

* * *

The Council has accepted the report of the Committee on Scientific Work and the Annual Meeting and it recommends to the House of Delegates that the 1949 annual meeting be held in Providence on May 11 and 12.

continued on page 692

In acute respiratory infections control of the distressing discomfort



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Alleviation of the many distressing symptoms associated with even minor upper respiratory infections is promptly obtained by Dasin. Presenting Dover's powder (½ gr.), aspirin (2 gr.), acetophenetidin (1½ gr.), camphor (¼ gr.), caffeine (⅛ gr.) and atropine sulfate (1/500 gr.), Dasin provides the analgesic, antipyretic and diaphoretic actions required for quick relief. Excess nasal and bronchial secretions are reduced. Average dose, 1 or 2 capsules every 2 or 3 hours.

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HOUSE OF DELEGATES

continued from page 690

The recommendations were briefly discussed and then Dr. Albert H. Jackvony moved the acceptance of all of them by the House of Delegates. The motion was seconded and the recommendations were unanimously adopted.

EXECUTIVE SESSION

Dr. Charles L. Farrell moved that the House go into Executive Session for the hearing of the reports on Public Relations, Veterans Administration Hospital, and the Health Insurance Committee. The motion was seconded and adopted.

Report of the Committe on Public Relations

Dr. Charles L. Farrell, Chairman of the Committee on Public Policy and Relations, read the report of his committee relative to its activities since its election by the House of Delegates in May, 1948. The report is attached to and made a part of these minutes. (Complete report is on file at the executive office for reading by members)

It was moved that the report of the Committee on Public Relations be accepted. The motion was seconded and adopted.

Report of the President on the V A Hospital problem:

Dr. Joseph C. O'Connell, President of the Society, reviewed the developments subsequent to the meeting of the House of Delegates meeting in May relative to the staffing of the Veterans Administration Hospital in Providence. He related as to how he had received a telegram from a member of Congress in Washington requesting him to go to Washington. He did so and there with a Congressional delegation he met with the medical staff of the VA and reviewed the situation regarding the appointment of a Dean's Committee in Rhode Island. He stated that the Society had no objection to the physicians named to the Dean's Committee but felt that the committee should be representative of all the academic colleges in the state and that this might be achieved by adding four additional members of the committee representing Providence College and four representing Rhode Island State College or else name a new committee of six with two representing respectively Brown, Providence College, and Rhode Island State.

Dr. O'Connell also stated that he received the impression from remarks made at the interview that the intern and resident program at the hospital might be started at a later date. He reported how subsequently the Providence newspapers carried a story of his visit and also the announcement that the Veterans Administration would not have an educational program for physicians at the hospital in Providence.

Dr. O'Connell asked for discussion of the problem by the House of Delegates and he reported that he had resolution prepared for possible introduction. He was requested to read the resolution. The resolution is as follows:

WHEREAS the House of Delegates of the Rhode Island Medical Society, assembled in official meeting on January 31, 1946, did resolve that it should endorse the policy outlined by Major General Paul R. Hawley relative to the utilization of the local medical profession for furnishing professional medical personnel for Veterans Administration hospitals, and did also express its desire then and subsequently to cooperate with the Veterans Administration in the operation of the hospital in Providence, proposing that in view of the fact that no medical school exists in Rhode Island the Rhode Island Medical Society be constituted the authority to deal with the Veterans Administration in the matter of nominating physicians to act as senior consultants, consultants, and ward of officers according to the established plan of the Veterans Hospital program, suggesting that consultants be appointed to serve not less than three nor more than six months in each year so that they may still be able to hold positions in civilian hospitals, and suggesting further that the Society be the authority to nominate practicing physicians as they are needed to fill vacancies in the staff of the Veterans Hospital both in its outpatient and in-patient departments, and

WHEREAS the Veterans Administration has seen fit now to reject this cooperation, and has also decided to eliminate a medical teaching program at Providence Veterans Administration Hospital,

THEREFORE, BE IT RESOLVED That the Rhode Island Medical Society hereby repeat its offer to cooperate with the Veterans Administration of the United States to the end that the



The Alkalol Company, Taunton 12, Mass.

veterans of this State and the adjoining State of Massachusetts may be guaranteed the same excellent medical care accorded all the people of this area in the private and public hospitals, and

BE IT FURTHER RESOLVED That the Rhode Island Medical Society urge the U. S. Veterans Administration to reconsider its decision relative to a medical teaching program at the Providence Veterans Hospital, utilizing a medical teaching staff from the medical profession of Rhode Island which now provides such programs at several Rhode Island hospitals to the advantage of the patients and for the important medical training of young physicians of this area.

After discussion of the problem Dr. Abbate moved the adoption of the resolution with the amendment elinimating the names of the hospitals. Dr. O'Connell asked the Executive Secretary to read the resolution adopted by the House of Delegates on January 31, 1946. Mr. Farrell read this resolution. The resolution before the House was then approved.

The question was raised as to whether the resolution just approved by the House of Delegates should be released to the press. Dr. O'Connell recommended that the resolution first be sent to Drs. Magnuson, Carroll and Cushing of the Veterans Administration and then be released to the press.

Remarks by Dr. Lawson

Dr. Lawson claimed the privilege of the floor and stated that he anticipated appointment as Chief of Medical Service at the Providence Veterans Hospital. He reviewed his relations with the Veterans Administration, and voiced his hopes for cooperation from the members of the Society in his assignment at the new hospital in Providence.

Dr. O'Connell congratulated Dr. Lawson on his anticipated assignment as Chief of Medical Service of the new hospital and stated that he felt that he was a physician eminently qualified for the position.

Report of the Health Insurance Committee:

Dr. Rocco Abbate, Chairman of the Committee on Health Insurance read a report of his committee. The report is attached to and made a part of the minutes of this meeting.

Dr. Charles L. Farrell discussed the report briefly. Dr. Troppoli asked if there was any action that the House should take. Dr. Abbate reported that the committee was working out details relative to its problems and there was no need at this time for the House to take any action pending a final report from the committee.

It was moved and adopted that the report on Health Insurance be accepted. The motion was seconded and adopted. (The complete report is on file at the executive office for reading by members)

REPORT OF THE DELEGATE TO THE AMERICAN MEDICAL ASSOCIATION

Dr. Herman A. Lawson, Delegate to the American Medical Association, reported on the meeting of the House of Delegates of that organization at Chicago in June, 1948. He reviewed the action taken on the resolutions introduced from Rhode Island relative to support of the Board of Trustees of the American Medical Association in their purchase of employees insurance through a private insurance company; relative to discrimination against the Rhode Island Surgical Plan by requiring a year's wait before issuing the Seal of Approval; and a criticism of the American Medical Association for failure to make a study of state cash sickness compensation plans.

He reported that the Council on Medical Service had taken cognizance of the resolution regarding the Rhode Island Surgical Plan and as a result the Seal of Approval has now been given to it. He briefly discussed some of the other highlights of the meeting. It was moved that the report of the Delegate be accepted. The motion was seconded and adopted.

continued on next page



HOUSE OF DELEGATES

concluded from preceding page

QUESTION OF INSURANCE FEES:

In the absence of Dr. William P. Davis, Chairman of the Committee on Medical Economics, the Executive Secretary reported on developments regarding the fees for physical examinations for insurance companies. He reviewed how the House of Delegates had taken action early this year and recommended that the fee for physical examinations for insurance companies, other than for Workmen's Compensation, should be $10.

He reported there had been repercussions from the insurance companies who refused to pay the fee or who dropped from their list some of the physicians who had previously served as medical examiners for them.

Mr. Farrell also reported that the New Jersey Medical Society had been faced with a similar problem and had carried a resolution to the House of Delegates of the American Medical Association in the opinion that the matter could only be settled finally at the national level. The American Medical Association resolution had been referred to the Bureau of Medical Economic Research and Mr. Farrell read a letter from the director of that department stating that it now has the matter under study.

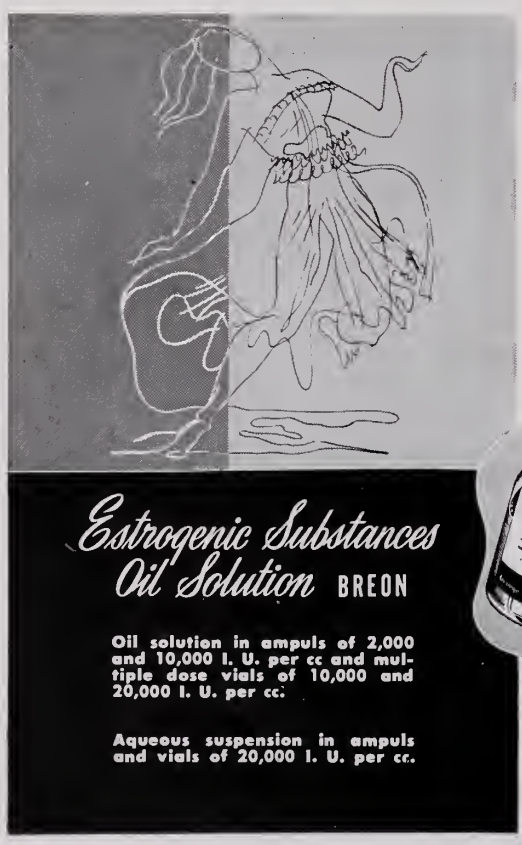
There was extensive discussion of the matter and Dr. Farrell climaxed it by stating that the Society has officially spoken in the matter and therefore every Fellow should cooperate, or if dissatisfied with the action should protest to the district society or the House of Delegates requesting that the action be rescinded, held in abeyance or otherwise considered. He expressed the opinion that every district should be notified of the action taken and should be requested to abide by the action of the House.

After further discussion the motion was made that a letter be sent by the Secretary of the Society to every Fellow, and in addition a letter to the Secretary of each district society to be read at it regular meeting, reviewing the action taken by the Society regarding insurance fees and stipulating that this was an official action of the Society which requires the response and cooperation of every Fellow until such time as the action may be changed. The motion was seconded and adopted.

The meeting adjourned at 10:45 p.m.

Respectfully submitted,

MORGAN CUTTS, M.D., *Secretary*



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BOOK REVIEWS

A MANUAL OF PHARMACOLOGY AND ITS APPLICATION TO THERAPEUTICS AND TOXICOLOGY, By Torald Sollmann, M.D. Phil.: W. B. Saunders Company. 7th ed., 1948. $11.50

This revised edition of Sollmann's book has some outstanding characteristics which make it an advance in pharmacological text books. The subject matter is presented in a manner which integrates the material discussed with its clinical applications. This characteristic is emphasized if the treatment of subject material in the new edition is compared with an older edition.

The present volume very adequately covers advances in such fields as the antibiotic agents, the antihistaminics, and the nitrogen mustards. The treatment of the older drugs is characterized by the emphasis on well established recent facts and the elimination of unnecessary speculation.

The bibliography is quite complete and the new arrangement of two columns to a page makes for easier reading.

W. J. H. Fischer, Jr., m.d.

DISEASES OF THE CHEST, Emphasizing X-ray Diagnosis, By Eli H. Rubin, m.d. W. B. Saunders Co., Phil., 1947. $14.50

The author has set himself a rather ambitious program and in so far as is possible I believe he achieves this goal. However, it must truthfully be said that the author rides off in all directions at once. He tries to be all things to all people, and because of this the book can be criticized justly.

First of all, for a trained Radiologist the X-ray discussion is too superficial and too sketchy. For the non-trained clinician, even if he is a chest specialist, the X-ray discussion is again, to my mind, inadequate.

With justice it must be said that the X-ray discussion ties in very well with the clinical data for those men who have had training in X-ray. Personally, I found the discussion of Tuberculosis possibly the best part of the whole book. Here, and throughout, the illustrations are excellent.

The author's arrangement of this vast subject is the best possible. From a Radiologist's viewpoint the chapters on pre-operative and post-operative care again seem comprehensive but sketchy.

In summary, it must again be said that criticism is directed to the objective of the book, which is too ambitious, rather than to the method of dealing with the subject. Had the author decided to write a book on Diseases of the Chest from a clinician's point of view, tying in, throughout, X-ray, physiology, and surgery as necessary, the book might even be better than it is. I found it very profitable reading, as I am sure others will.

Eugene A. Field, m.d.

GENERAL ENDOCRINOLOGY, By C. Donnell Turner, ph.d.

W. B. Saunders Co., Phil., 1948. $6.75

This is a very readable and up-to-date textbook of Endocrinology. It is written from the point of view of general biology rather than medicine. It presents the subject in a broad way, as an experimental science. While a large part of the material is mammalian, the lower vertebrates and the invertebrates, especially the insects, are adequately treated. Plant hormones are included in the general discussion. The introductory chapter includes a summary of the history of endocrinology and is followed by a chapter on the biology of secretion which treats of chemical coordinators in the organism generally and serves as a background for the specialized chapters that follow. The illustrations are well chosen and excellent. There is an adequate bibliography at the end of each chapter in which preference is given to monographs and recent reviews. While it is designed primarily for students in a university course, the book is heartily recommended for the general reader.

J. Walter Wilson
Brown University

SYMPOSIA ON NUTRITION OF THE ROBERT GOULD RESEARCH FOUNDATION, Vol. I, Nutritional Anemia, Edited by Arthur Lejwa, The Robert Gould Research Foundation, Inc., Cincinnati, Ohio, October 16, 1947.

This volume comprises a series of eleven papers prepared by oustanding hematologists for a recent symposium. The papers bear principally upon those aspects of anemic diseases which are influenced by nutritional factors such as folic acid, iron,

copper, the vitamin B complex and vitamin C. The papers herein presented will have their chief value as sources of reference (they have rather extensive bibliographies) and for those whose primary interest is hematology or nutrition.

IRVING A. BECK, M.D.

***ADVANCES IN INTERNAL MEDICINE,* Vol. II. Edited by William Dock, M.D. and I. Snapper, M.D. New York: *Interscience Publishers, 1947.* $9.50**

The aim of this series to brief the internist and others on outstanding recent advances in internal medicine and related fields is well met. A wide range of subjects is presented.

In the field of the cardiovascular system the section on "Circulatory Failure Studied by Means of Venous Catheterization" and the "Discussion of Angiocardiography and Angiography" are particularly important, especially for those who have not had an opportunity to work directly in these fields.

The section on "Surgical Treatment for Hypertension" points out the outstanding problems in this field. The tendency to increasingly extensive sympathetic denervation is noted. The discussion of the use of penicillin in bacterial endocarditis and in other infections has as its only failure the almost unavoidable one of not being able to present material in a fast moving field which is not somewhat outdated when it is published. The section on the anemias contains a good consideration of what has been recently one of the most interesting developments, namely, the role of Folic Acid. The indexing is detailed and entirely satisfactory.

W. J. H. FISHER, JR., M.D.

A-B-C'S OF SULFONAMIDE AND ANTIBIOTIC THERAPY, by Perrin H. Long, M.D., F.R.C.P., W. B. Saunders Company, Philadelphia and London, 1948.

This is a concise summary of our present day knowledge of sulfondamides and antibiotics. It apparently is designed primarily for the busy practitioner so there are no lists of references and the information is set forth explicitly and unequivocally. The very arbitrariness of this presentation leaves the author open to criticism that he has not included certain divergences in current opinion. However, when devising a book for actual use by individuals possessing no special training in the changing field of infectious disease therapy it is perhaps the wiser plan to have a certain arbitrariness of presentation. Advise as to therapy has been simplified by outlining standard dosage schedules which are applicable to a number of different infections. There is a brief outline of the clinical pharmacology of these medications. Under toxic mani-

continued on next page

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Next Meeting

PROVIDENCE MEDICAL ASSOCIATION
MONDAY, DECEMBER 6

BOOK REVIEWS
concluded from preceding page

festations the author cites a warning which, unfortunately, has not received sufficient attention, namely, that the quickest and most consistent method of producing a generalized sensitivity is by the local treatment of open dermal lesions with topical preparations of penicillin or the sulfonamides.

Most of the common infectious diseases in which one or both of these forms of therapy may be applicable are listed in alphabetical order and the treatment of choice given. The author is forthright in indicating that in certain conditions in which these drugs are at present used rather widely, such as the common cold or influenza, their use is unnecessary, wasteful, and may lead to sensitization. A description of auxiliary therapy has been included for many of the diseases.

The conciseness, the explicitness, and the relatively small physical size of this volume make it available as a quick, practical reference without detailed reading, such as one might want on the practitioner's desk or in the interne's coat pocket.

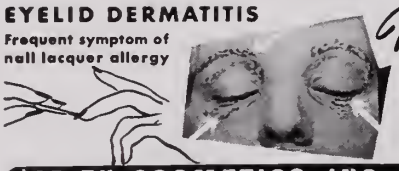
IRVING A. BECK, M.D.

CORRELATIVE NEUROANATOMY By Joseph J. McDonald, M.S., M.Sc.D., M.D., Joseph G. Chusid, A.B., M.D., Jack Lange, M.S., M.D. Fourth Edition, Revised (60 Illustrations), *University Medical Publishers, PALO ALTO, CALIFORNIA*

This presentation is the fourth revision of this useful text which was first issued in 1938. Its usefulness is derived from its composite arrangement which is simple but more complete than many more noted textbooks; and its availability since it is within the price range of all students and practitioners. This has been made possible by outline form in lithoprint, reproduction of flat drawings, and loose-leaf type of binding.

The principles of neurodiagnosis are presented in correlation with anatomical divisions of the nervous system rather than with clinical entities as presented in earlier editions. The section on diseases of the central nervous system follows an eclectic arrangement, augumented by more detailed descriptions and a more complete list of syndromes. The bibliography is short but refers the reader to standard works of proven reliability. The illustrations, set opposite the related anatomical descriptions are one of its best features.

HANNIBAL HAMLIN, M.D.

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PROVIDENCE MEDICAL ASSOCIATION

concluded from page 683

Dr. Wilson gave an excellent paper on beryllium poisoning. This substance is used in fluorescent lighting, electronics etc. The dust is inhaled and causes lung damage. The condition may be acute or may be chronic, also the symptoms may not become manifest for three years after exposure.

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Dr. Ham had one patient with this disease. He was extremely sick and upset mentally and it was difficult to distinguish the nervous reactions from the reactions to the disease. This patient ended with extreme cyanosis and clubbed fingers, with frequent exacerbations of the disease.

The meeting was adjourned at 11 p.m.

Attendance 65

Collation was served.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D., *Secretary*

READY TO HELP CARDIAC CHILDREN

The Children's Heart Association of Rhode Island reminds the physicians of the State that it stands ready to help them in the care of those children with heart disease. The Association will arrange to set up programs of education, occupational therapy, and volunteer visiting in order to relieve to some extent the patient's burden of weeks in bed, as well as offer relief to the parents of the patient. The Association also conducts a camp program in the summer. To a limited extent the Association can arrange for supplementary financial assistance in some cases requiring convalescent hospital care.

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PALMINO DIPIPPO, M.D., 1536 Westminster Street, Providence 9, Rhode Island.

CHARLES DUNBAR, M.D., 10 Appian Way, West Barrington, Rhode Island

HENRY B. FLETCHER, M.D., 196a Waterman Street, Providence 6, Rhode Island

FRANK GIUNTA, M.D., 403 Montgomery Avenue, Providence, Rhode Island

JAMES F. HARDIMAN, M.D., 432 Public Street, Providence, Rhode Island

ROBERT C. HAYES, M.D., 166 Pawtucket Avenue, Pawtucket, Rhode Island

ALFRED KANT, M.D., Mass. Eye and Ear Infirmary, Boston, Massachusetts

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JAMES P. MCCAFFREY, M.D., 116 Waterman Street, Providence 6, Rhode Island

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GEORGE H. TAFT, M.D., 8 Myrtle Street, Providence, Rhode Island

MALCOLM WINKLER, M.D., 199 Thayer Street, Providence 6, Rhode Island

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H. I. BIXBY, M.D., 21 Park Street, Attleboro, Massachusetts

JOSEPH H. COLMAN, M.D., 48 Bank Street, Attleboro, Massachusetts

JOHN T. COTTER, M.D., 188 Commonwealth Avenue, Attleboro Falls, Massachusetts

CARL J. DEPRIZIO, M.D., 21 Park Street, Attleboro, Massachusetts

MAURICE D. GRANT, M.D., 171 North Washington Street, North Attleboro, Massachusetts

WILLIAM J. MORSE, M.D., 34 Danford Street, Attleboro, Massachusetts

FRED V. MURPHY, M.D., 79 Bank Street, Attleboro, Massachusetts

WILLIAM M. STOBBS, M.D., 63 Bank Street, Attleboro, Massachusetts

MID-WINTER MEETING

OF THE RHODE ISLAND MEDICAL SOCIETY

WEDNESDAY, FEBRUARY 2, 1949

AT THE U. S. NAVAL AIR STATION

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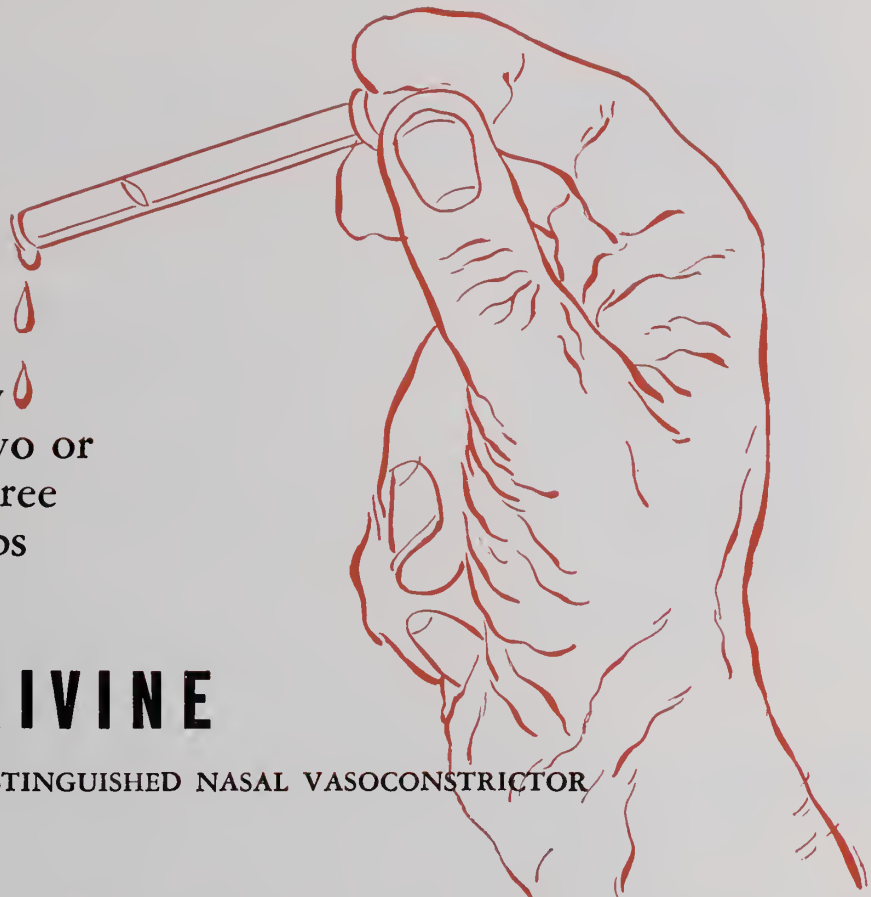
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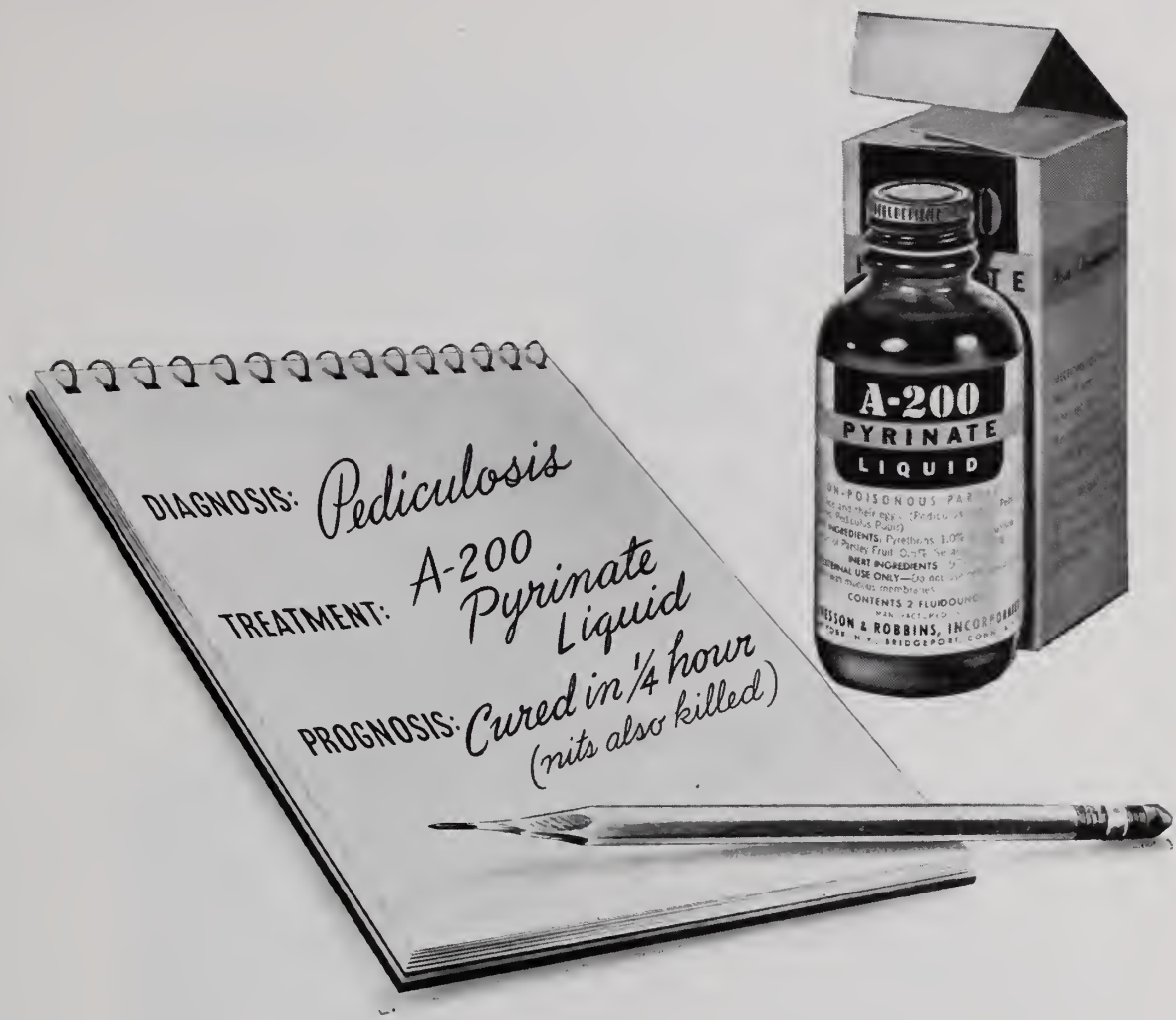
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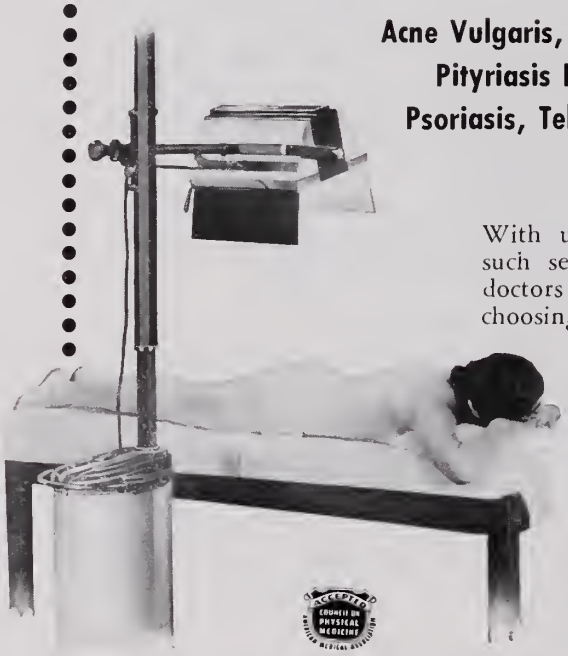
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Vol. XXXI, No. 12 December, 1948

TABLE OF CONTENTS

Page

Berylliosis, *Stanley A. Wilson,* M.D. ... 719

Spinal Anesthesia in Vaginal Deliveries, *Walter J. Dufresne,* M.D. *and Howard W. Umstead,* M.D. ... 723

Myxedema and Psychosis, A Case Report, *James J. Scanlan,* M.D. ... 725

What Good are Health Museums? *Bruno Gebhard,* M.D. ... 732

EDITORIALS

Internal Medicine in Central Europe ... 728

Case Finding in Tuberculosis ... 730

Changes ... 730

Cancer Conference ... 731

Rhode Island Hospital Staff Dinner ... 731

MISCELLANEOUS

Book Reviews ... 748

Cash Sickness, Sample Study of Claims ... 744

College of Surgeons, New Fellows from Rhode Island ... 743

District Medical Society Meetings ... 738

Index of Advertisers ... 755

Malpighi Medical Club, Report of meeting ... 743

New England Leaders ... 727

Medical Library Notes ... 740



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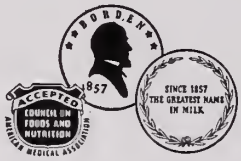
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*Philip Lewin, M. D., F.A.C.S.
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1. J. Pediat. 32:1 (1948).
2. Am. J. M. Sc. 213:513 (1947).
3. J. Pediat. 32:119 (1948).
4. New England J. Med. 236:817 (1947).
5. New York State J. Med. 48:517 (1948).
6. Lancet 1:255 (1947).

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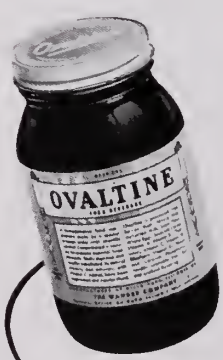
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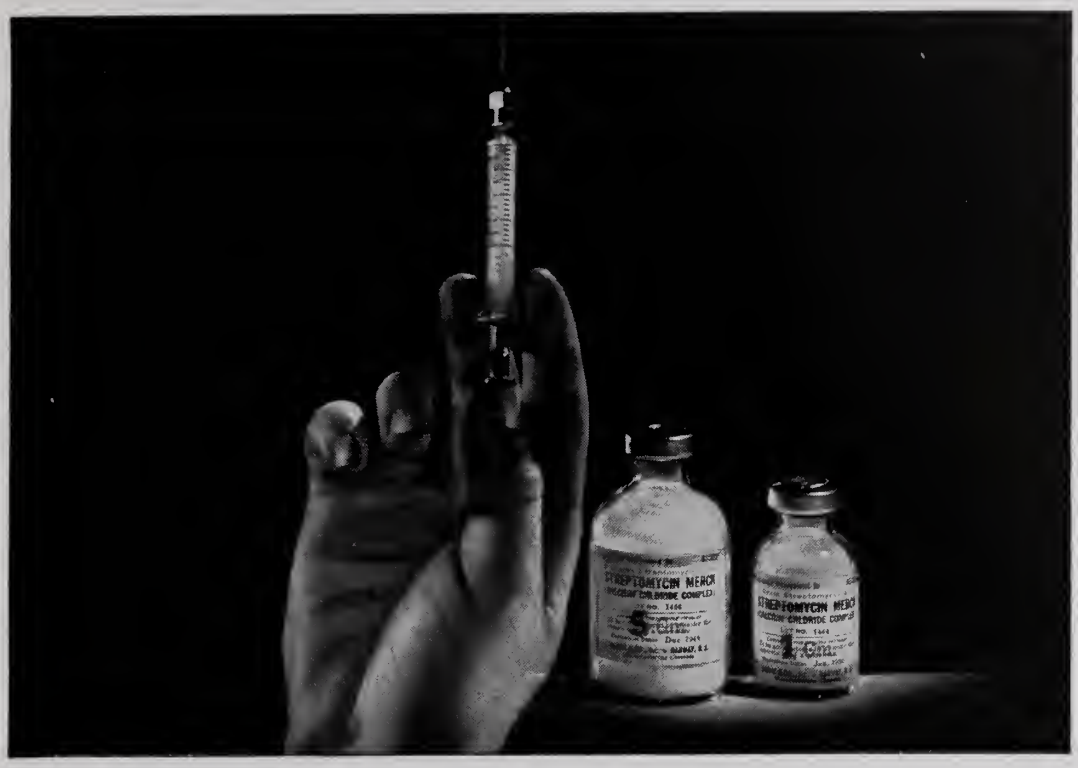


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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXI DECEMBER, 1948 NO. 12

BERYLLIOSIS*

STANLEY A. WILSON, M.D.

The Author. *Stanley A. Wilson, M.D., of Salem, Massachusetts. Roentgenologist, Salem Hospital.*

IN THIS PAPER the disease will be referred to as Berylliosis, since, in the opinion of the author, sufficient evidence has accumulated to indict Be and its compounds as the main etiological factor, if not the only one. There is not full accord on this point, therefore the term Berylliosis has not been universally accepted as the proper nomenclature; but its use is becoming much more common. Various titles have been applied to the condition in the past, such as, "Pneumonitis of Be Workers," "Pulmonary Granulomatosis of Be Workers," "Delayed Chemical Pneumonitis," and others. The most significant evidence in condemning Be is the occurrence of similar disease in several different industries in which the only common denominator is Be in some form.

Be is not a commonly known element, therefore, a short description of it and its uses seems pertinent to this discussion. In nature, it occurs most commonly as a double silicate with aluminum in the ore known as Beryl. The metal is soluble in acids, and these are used in the process of its extraction. (This is significant as the acid radicle has been blamed for the acute pneumonitis occurring in workers extracting ore). In the pure state, Be is a brittle steel grey substance which resists rolling, drawing, and filing as it turns to powder when machined. Small amounts added to other metals, however, produce alloys of great tensile strength and low fatigue rate which are non-magnetic, do not spark, and are good conductors of electricity. This knowledge explains its high priority rate during the recent war and its popularity in industry since. Other uses to which it is put are in the manufacture of ceramics, x-ray tube windows, phosphors used in fluorescent lighting and signs, atomic energy piles, research laboratories, pharmaceutical plants, electronics, and undoubtedly many others still uncovered.

Its use was very limited in this country prior to 1940 and probably explains the absence of any reference to its toxicity in our own medical literature until 1943, though several articles had appeared in European journals dating back to 1933. Our attention was first called to it by VanOrdstrand, Hughes, and Carmody in an article entitled, "Chemical Pneumonia in Workers Extracting Beryllium Oxide," which appeared in the Cleveland Clinic Quarterly, 1943. In that same year, Hyslop, Fairhall and their associates discussed the toxicity of Be in an article appearing in the Nat. Inst. of Health Bulletin. Kress and Crispell of the Guthrie Clinic described a chemical pneumonitis in men working with flourescent powders containing Be in 1944. These reports all dealt with what has been considered the acute type. In recording the findings in 38 cases of the acute form in which 5 terminated fatally, VanOrdstrand and his associates bring out the following facts: The incidence and severity are proportionate to degree of exposure and chemical irritation of dusts and fumes. No single work station could be isolated, and the duration of exposure varied considerably. Most of the patients recovered in a few weeks or months following rest and removal from exposure, but recurrence took place with re-exposure. The onset was insidious but was not a delayed reaction. It was characterized by cough and occasional dull, burning substernal pain. Dyspnea soon followed onset of the cough, and cyanosis became evident in some cases. Abnormal taste, anorexia, weight loss, and increasing fatigue were consistent findings. Absence of signs of infection, a rapid pulse, very little elevation of temperature, and absence of pathogens in the sputum were significant findings.

In 1942, a middle-aged female employee of a flourescent lamp plant developed a peculiar pul-

continued on next page

* Presented before the Providence Medical Association, October 4, 1948, under title "Pulmonary Changes occurring In Beryllium Workers."

monary disease with diffuse miliary lesions in both lungs demonstrated by a roentgenogram of the chest. She had suffered from progressive loss of weight, dyspnea, and cough, because of which she was referred to a T.B. sanatorium where several diagnoses were entertained. She eventually expired from what was thought to be edma of the larynx and was signed out as pulmonary sarcoidosis. A similar diagnosis at that time was returned by the pathologist who conducted the autopsy. The case aroused only passing interest, until during the following year, ten other employees in the same plant became ill with similar clinical history, physical and roentgen findings. It then became apparent that an industrial hazard must be considered, and Tabershaw and Hardy of the U. S. Public Health and Dept. of Occupational Hygiene for the State of Massachusetts were called in. After studying the available clinical records of these eleven cases and six others, they published a report in the Journal of Industrial Hygiene and Toxicology of 1946, offering the title, "Delayed Chemical Pneumonitis." In 1947, Higgins reported the same series in the Conn. State Medical Journal calling it, "Pulmonary Sarcoidosis." The late Leroy Gardner, after considerable clinical and experimental research, suggested the title, "Pulmonary Granulomatosis."

The roentgenological study of these cases since 1942, and opportunity for clinical follow-up as well, since 1947 has been the privilege of this author. Over fifty cases are now included with eight deaths, several of which have been studied at post-mortem. The series includes fifteen males and the balance, females with no fatalities in the male group. This ratio of males to females corresponds closely to the employment census. All of them were exposed during the years 1940 to 1942 when phosphors used in the manufacture of flourescent lamps in this plant contained 12% Be. No employees exposed to the lower percentage (2%) of Be phosphors since 1942 have shown any evidence of disease.

In preparation for this presentation the histories of thirty-nine of the group were reviewed. These showed that 5 developed symptoms within one year following exposure, 6 in two years, 9 in three years, 8 in four years, and 2 in six years. Analysis of presenting symptoms at onset of disease revealed that cough, dyspnea, and weight loss either singly or in combination were most common. Cough — 19. Dyspnea — 15. Weight loss — 15. Fatigue — 9. Nervous irritability — 6. Chest pain — 4. Neuro-muscular or arthritic pain — 3. Gastro-intestinal symptoms — 3. As the course of their disease progressed, many or all of these symptoms developed in nearly every case. The onset in one was complicated by hyperthyroidism, another by typhoid fever, and eleven followed pregnancy. Four were symptom-free and picked up by routine chest roentgenograms. A recent survey will add at least three more to this latter group.

The final diagnosis has been greatly dependent upon recognition of roentgen changes combined with clinical history, but physical examinations and laboratory findings have been necessary parts of the study in order to rule out other conditions. No one procedure has rendered any information which can be termed pathognomonic of this disease, but since the roentgenological examination plays such an important role, more space has been devoted to it in this presentation. This necessitates a consideration of, at least, two forms of response; namely, acute and chronic as has been denoted clinically. The type and degree of exposure, including particle size, percentage air saturation, duration, solubility of the compound inhaled, and many other factors must be considered in determining the reason for this difference in reaction and, therefore, the roentgen pattern. In this study, an attempt has been made to reconstruct the probable changes taking place and correlate these with the x-ray findings. In doing so, Sayer's classification of dust exposures has been followed. Time does not permit a description of this classification and is not necessary to the following description of the roentgen findings.

In the acute cases, there is similarity of roentgen pattern which would lead one to suspect that they might be due to the same cause, but there is a variation to be noted in some. In the course of the disease, there is one significant finding; namely, the delay between onset of symptoms and the first appearance of roentgenological evidence of pathology. Increased linear markings and some granularity consistent with pulmonary congestion might be expected as the first positive roentgent evidence of disease, but the ground-glass density of pulmonary edema seems to manifest itself two to three weeks after onset of symptoms. It does not necessarily involve both lungs uniformly or completely but may confine itself to the mid-lung field or base in one or both sides. This seems to resolve itself into shadows of a denser character indicative of consolidation in either a lobar or bronchial distribution. With clinical improvement, a granular and nodular pattern with conglomerate masses asserts itself for a time before clearing of the lung, following which there may or may not be signs of residual fibrosis. Clearing has usually taken place within one to four months and before all clinical evidence of the disease has disappeared. If one reviews these findings, it is apparent that there is no significant roentgen change that cannot be associated with the various acute pneumonias due to other causes. The history of exposure, absence of

pathogens, and other signs of infection are helpful in diagnosis, however.

CHRONIC PULMONARY GRANULOMATOSIS—Delayed onset of symptoms and roentgen evidence of disease following exposure has been a characteristic feature in Chronic Pulmonary Granulomatosis of Be Workers. Either due to absence of symptoms and failure to obtain frequent examinations, inability to carry on a careful follow-up on exposed personnel, or what seems more likely, actual lack of significant variation from the normal, x-rays have failed to provide an early diagnosis during the latent period. Following the recognition of this as an industrial hazard in 1943, a prompt mass survey by chest roentgenography was conducted in the plants where exposure was suspected. Unfortunately, all of the fourteen hundred persons now believed to have been exposed could not be examined, but a large percentage of them was included in the series. From this study, only three accepted cases and five suspected cases have been uncovered. The others were all considered essentially normal. In spite of this, several cases have developed disease in the group examined. One, at least, within a month after having had normal roentgen findings, showed symptoms and a characteristic roentgenogram. The original films of these cases were reviewed by a number of competent radiologists, and in nearly every instance the consensus was that the findings were within the range of normal.

The changes seen in accepted cases offer a roentgen classification of types or stages as follows: 1. Granular. 2. Granulonodular. 3. Nodular with emphysema. The earliest recognizable abnormality has been a fine sandlike pattern or stippling throughout both lungs and evenly distributed from apices to bases. This type of response possibly represents interstitial thickening due to congestion and edema. It appears more particulate than the usual conception of pulmonary edema, however, and probably is a manifestation of early fibrous change with small granuloma formation. This type may persist for many weeks or months, and in a few cases has been seen throughout the course of observation over periods of one to five years. Either it does not occur, or has progressed to a later stage in other cases, as the presenting roentgenograms at the onset of symptoms in some have shown distinct nodularity. The highest percentage of cases showing a persistent granular pattern but with fine nodularity has been noted among the male patients, who show less disability. Whether this has any significance has not yet been determined. In Type I or Stage I of the disease, prominent lung root shadows and vascular markings do not seem to be featured and may be obscured. There are no recognizable signs of emphysema, pleural or cardiac complications.

The second type or Stage II shows more prominent nodulation with a somewhat reticulated pattern and the sandlike background still present. The nodularity, too, appears more or less uniform in size and distribution but, at times, with apparently more involvement in some portions of the lung fields than in others. The outline of the lung root shadows and the usual linear markings are indistinct, but paratracheal and hilar masses are frequently visible. There is little recognizable emphysema present, and only occasionally does there appear to be definite evidence of early cor-pulmonale with prominence of the pulmonary artery and right-sided enlargement. Such roentgen findings may persist for many months and, in most instances, progress to a form designated as Stage III. In three cases it has been possible to positively state that regression of roentgen findings has taken place, but before they had reached Stage III. One shows residual linear fibrosis with no nodulation, the others still have indistinct nodulation, and all have diminished pulmonary function.

In Stage III, the nodular shadows have become larger but still do not exceed five millimeters in diameter and may be as small as one. Between these, there are now clear areas of varying sizes, which undoubtedly represent emphysematous spaces with intervening linear fibrosis. Portions of the lung fields, particularly the bases, give the impression of clearing, but this is usually due to increasing emphysema rather than improvement in the disease. The excursion of the diaphragms is limited, fluoroscopically, and the short septum on the right becomes prominent and elevated. The upper lobes, particularly the right, become smaller because of partial atelectasis, and their density increased by closer packing of the nodular coalescence of the lesions. Signs of cor pulmonale are usually quite apparent at this time. Eight of the cases have suffered spontaneous pneumothorax. Four of these have experienced severe pulmonary and cardiac embarrassment. There have been no signs of pleural effusion in any of these cases, and the air in the pleural cavity has been absorbed in about two weeks with no apparent complications. In fact, four of the cases have seemed to improve for a time following recovery from this episode. To date, there has been no instance of a reversal of the process after Stage 3 has been reached.

These represent the types or stages encountered in a group of over fifty cases exposed to lamp phosphors containing zinc manganese beryllium silicate. A smaller series with similar roentgenographic changes have been studied where the exposure compound was either beryllium metal, the oxide, or possibly one of the acid salts. A group of cases

continued on next page

exposed to beryllium in the production of alloys at a metallurgical plant have shown a somewhat different combination of roentgenological findings, however. The sandlike densities and the nodularity have been present but in less uniform distribution. The most significant difference from the above groups has been the development of large conglomerate masses or areas of consolidation and prominent linear fibrosis.

X-ray examinations of other systems in many of the chronic cases have been consistently negative with the exception of the urinary tract. Six cases of urinary calculi have occurred. The bony skeleton has not shown any significant abnormality.

Before considering differential diagnosis, certain roentgenological features of this disease should be emphasized. In the chronic form, the characteristic lesion is a small granuloma which manifests itself as a small granular or nodular shadow in the roentgenogram. There is miliary and somewhat uniform distribution. They do not, in most instances, coalesce to form large lesions but can occasionally and appear as conglomerate masses. They do not calcify or cavitate, and the pleura does not appear to be involved. An earlier report of these cases inferred that the sandlike pattern as described was almost pathognomonic. It does characterize this disease but may be encountered in other conditions which stimulate a similar pulmonary response and cannot be entirely relied upon. Differential diagnosis is not easy, and one must depend upon history, clincal findings, laboratory studies, and the law of averages, as well as the x-ray examination. Conditions which may be confused with chronic berylliosis are many. Other diseases which can produce miliary nodular shadows in the lung fields must be considered even though this is not their usual manifestation.

The pathological findings in the acute cases were those of atypical pneumonitis, pulmonary edema, and hemorrhagic extravasation. Plasma cells were found in large numbers, but there was a relative absence of polymorphonuclear infiltration.

The lesion seen in the so-called chronic pulmonary granulomata occurring in beryllium workers is recognized grossly as very small, pinhead-sized, whitish nodules found diffusely throughout the lobes of the lung. The draining lymph nodes occasionally are enlarged and may show areas of a granular, grayish white necrosis partially or completely replacing the lymph node. Microscopically the lesions are found both within the air sacs and in the supporting framework of the lung, and it is thought that several different stages of development are to be recognized. The earliest lesion is usually seen within the alveoli and consists of aggregations of large mononuclear cells, so-called histiocytes, associated with a moderate amount of edema. Later, nodules within the framework of similar histiocytes are seen which are surrounded by a zone of lymphocytes and occasional plasma cells. The next phase is that of necrosis within the central masses of the histiocytes occasionally associated with the presence of large foreign body type giant cells and with increasing fibrosis about the periphery of the granuloma accompanied by a moderate accumulation of lymphocytes and plasma cells. The end stage is represented by an area of marked hyalimization. With special stains the reticular framework within the early granulomas is destroyed in the stages in which necrosis is present and in some of the earlier granulomas there appears to be a distinct increase of reticulum either arising from blood vessels or possibly being formed by histiocytes.

No specific treatment has been found for this disease, though every known means has been tried to improve the exchange of gases in the lungs. Most cases are treated symptomatically with oxygen therapy and rest as the chief stand-bys. High protein diet, vitamins, sedatives, etc. all have their place, but care of these cases can be, and is, very discouraging. Many cases show improvement, some are clinically well, a few show roentgenological improvement, but many are slowly, yet progressively, becoming worse, or at best, remaining stationary. Some have periods of improvement followed by recurrences of severe cough and dyspnea, possibly explained by secondary infection or cardiac decompensation. All show lowered vital capacity and decreased breath-holding time which may be used as a rough guide in evaluating symptomatic improvement.

Before concluding, some mention should be made of the extensive research being carried out, control of the hazards, so-called "neighborhood cases," the skin manifestations, eye complications, and methods of determining the presence and amounts of beryllium in tissues and excretions of the body, but these could easily fill another paper.

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SPINAL ANESTHESIA IN VAGINAL DELIVERIES*

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OBSTETRICAL ANESTHESIA had its beginning during the reign of Queen Victoria when ether and chloroform were first used to alleviate the travail of labor. Until this time, the biblical dictum "In sorrow thou shall bring forth children" was accepted without reservation and any attempts to lessen or shorten the tortures of labor were considered sacrilegious. However, Queen Victoria requested chloroform anesthesia when delivered by John Snow and a new era was begun.

From that time on, man has marched steadily forward in his fight against pain. Chloroform, ether, chloral hydrate, nitrous oxide, cyclopropane, paraldehyde, morphine, scopolamine, demerol, and the barbiturates have all enjoyed varying degrees of popularity. It has been found that it is not good practice to prescribe by rule of thumb, the same anesthesia for all obstetrical cases. There is no one form of pain relief suited for every case. With each problem, one considers the existing complications, the position and condition of the baby, and the limitations of the attending anesthetist.

Spinal anesthesia in obstetrics was reported as early as 1900 by Kreis,[2] in 1928, Pitkin and McCormack[1] introduced a form of spinal anesthesia. A saddle type anesthesia obtained by anesthetizing only the sacral segment of the cord, the cervix, vagina, perineum, vulva and the sphincter of the bladder and the anus were affected. The body of the uterus was not affected. The labor pains proceeded unabated but because of the high degree of relaxation of the outlet, the actual delivery was quick, easy and painless. The first injection usually lasted 1½ hours and was repeated if it proved insufficient to complete the delivery (20 mg. of procaine in hypeboric spinal mixture). From that time on spinal anesthesia has steadily grown in popularity and during the past ten years, there has been many favorable reports appearing in anesthesia and obstetrical journals. Of the recent investigators, Cosgrove has accumulated the largest series of deliveries under spinal anesthesia. In 1937, he and Gleason reported on their experiences in 2789 cases[3] and reported the procedure highly satisfactory. A recent communication from Dr. Cosgrove states "spinal anesthesia is not the most frequently used here at Margaret Hague for vaginal deliveries, because in the hurry of a very active service, inhalation anesthesia is less time consuming and troublesome, but it is still our method of choice whenever either the mother or the baby is considered to be in any way handicapped."

In June, 1946, Dr. Weaver[4] and his associates at the Hamilton General Hospital of Ontario, reported on their experiences in 1547 cases and stated in the conclusions, there were no maternal deaths. Stillbirths and neonatal deaths have been definitely fewer than with general anesthesia. The local popularity both with patients and physicians have increased steadily.

About a year ago, we made an attempt to apply spinal anesthesia at the Memorial Hospital for vaginal deliveries, but our early enthusiasm was dampened by a high incidence of spinal headaches. For some unexplained reason, the pregnant female was more prone to develop a spinal headache than her non-pregnant sister, who received a spinal anesthesia for general surgery. Because of this troublesome complication, we used this method in only about 30 vaginal deliveries during the year.

Recently, it came to our attention that Dr. Wolff[5] attributed spinal anesthesia headaches to traction by the brain on various pain sensitive structures which anchor it to the cranium. Such traction follows a disturbance in intercranial hydrodynamics which is brought about by leakage of the spinal fluid at the puncture site. This may be partly or completely alleviated by the use of a smaller needle. We have substituted a 22 gauge needle in place of the usual 19 or 20 gauge needle and have had no headaches in 10 or more cases.

Throughout the year an attempt has been made to develop a good spinal technique. Numerous patients requiring low spinal anesthesia for gen-

continued on next page

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eral surgery have received varying mixtures of pontocaine in 10% dextrose, pontocaine in 5% dextrose, and pontocaine dissolved in spinal fluid. Thus far, we have had the best results with a mixture of 1% pontocaine and 10% dextrose. This mixture permits the greatest reduction in the amount of anaesthetic drug consistent with an anesthesia of suitable duration and extent. Very early in our experience with obstetrical patients, it was found necessary to achieve a level of skin anesthesia to a point about one inch below the umbilicus in order to obtain a complete relief of pain. If the anesthesia fixes at a lower level most patients will continue to have pain with each uterine contraction and more severe pain when traction is made during forceps delivery. It was also found important to consider the length of the patient's spine if the amount of anesthetic was to be kept at a minimum. In the majority of patients, it is sufficient to know their height and use this measurement as an indirect determination of the length of their spinal column. With other patients who show an obvious disproportion in the length of their legs as compared with the length of their trunks, a moment is required to measure the length of the spine. The spine is measured in a flexed position from the prominence of the spinous process of the 7th cervical vertebra to the 4th lumbar interspace. It was found that the very short patient is the most frequent offender in the disproportion. In this way, each patient can be properly accommodated to the dosage table and a higher percentage of satisfactory anesthesias will be obtained. Our present scheme for determining the proper dosage is listed below. We expect that some minor changes will be made as our experience increases.

Height	*Average Length of Spine*	*1% Pontocaine*	*10% Dextrose*
4′ 9″ to 5′ 1″	15″	0.3 c.c.	1.2 c.c
5′ 1″ to 5′ 3″	16″	0.4 c.c.	1.2 c.c
5′ 3″ to 5′ 5″	17″	0.5 c.c.	1.4 c.c
5′ 5″ to 5′ 7″	18″	0.6 c.c.	1.4 c.c.
5′ 7″ to 5′ 10″	18½″	0.7 c.c.	1.6 c.c.

The smaller amounts are more accurately measured by using double the quantities and discarding half of the resultant mixture. These mixtures have been used in a large variety of patients of varying ages and illnesses. Thus far in only a very few instances has it been necessary to give supportive treatment for excessive blood pressure fall occurring soon after the spinal injection. However, one must always be prepared to administer ephedrine or some other suitable vasoconstrictor intravenously should the occasion arise.

A means of supporting respiration and administering oxygen is essential for anyone who attempts a spinal anesthesia. The technique followed for administering spinal anesthesia is as follows. With the table in a horizontal position, the patient is placed on her side in the usual position for a lumbar puncture. A moderate dose of ephedrine (40 mg.) is given in the buttocks five minutes before injecting the anesthetic mixture. A skin wheal is then raised between the 4th and 5th lumbar spines and the lumbar puncture is made in the 4th lumbar space with a 22 gauge needle.

A mixture of pontocaine and dextrose is injected at the rate of approximately one c.c. per second and no spinal fluid is aspirated into the syringe either before or at the end of the injection. After the needle is withdrawn, the patient is turned to a dorsal recumbent position without delay. Approximately 7 minutes should elapse before moving the patient into a delivery position if the best results are to be obtained. With careful attention to dosage and technique a high percentage of the anesthesia will be fixed at a level of either the 9th, 10th or 11th dorsal segment, that is, in the area between a point two inches above the umbilicus and a point one inch below the umbilicus. A small percentage (approximately 2%) may extend to levels above the 9th dorsal segment if preventative measures are not instituted. Hence, it is essential to follow the progress of the anesthesia clinically and to retard the upward spread of the heavy anesthetic mixture whenever unnecessarily high levels appear likely. One soon learns the usual rate of spread and recognizes without difficulty those cases showing a tendency toward levels above the umbilicus. The sitting position, Fowler's position, or elevating the shoulders on pillows will correct the situation and protect these patients. Twelve minutes after injecting the anesthetic solution the anesthetic drug is "fixed" in the nerve tissue and will not be influenced by changes in position. The upper level of the anesthesia will last approximately 1 to 1½ hours. Soon after that time, labor pains will recur if the baby has not been delivered. The application of traction such as accompanies forceps delivery will also cause pain at this time. Anesthesia of the perineum, however, is present at the end of 1½ to 2 hours and sometimes even longer. With this time limitation considerable obstetrical judgment must be employed to designate when the anesthesia should be administered. Full dilatation of the cervix in the primiparous patient is necessary if anesthesia failures are to be avoided.

With the multipara, each case presents a new problem as to the most opportune time to give the injection. Most of our experience has been confined to primipara except for a few multip who presented obstetrical complications. All but two of our cases have required forceps delivery. Because of the anesthesia, patients do not feel their contractions nor do they have a desire to bear down. The incidence of forceps delivery can be cut down 10% to 50% if the patient is encouraged to push down

continued on page 727

MYXEDEMA AND PSYCHOSIS*

— A Case Report —

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THE INTIMATE association of mind and body is nowhere more forcibly illustrated in the field of medicine than in the psychic manifestations of endocrine disease. The effects of a distorted endocrine pattern are mirrored in the individual's mind equally as much as they are in his physical end organs. The evidence for this positive interdependence of "psyche" and "soma" is all the more striking when the mental disturbances attendant upon an endocrinopathy are restored to normal by hormone substitution therapy.

Myxedema presents an endocrine dysfunction that is amenable to cure by replacement therapy; hence, in the course of treatment one might expect the alleviation of its associated psychic and psychomotor symptoms. Characteristically, these symptoms belonging to the hypothyroid state consist of inability to concentrate, apathy, clouding of the consciousness and a general sluggishness of mental reactions. Occasionally, however, as in the case presented here, genuine psychoses develop.

The patient was a forty-seven year old, Norwegian-born woman whose chief complaint on entry into the hospital was one of extreme weakness and lethargy. These symptoms had begun three years before admission at about the time of her menopause. She first noticed a tendency to tire easily, which progressed as time went on to the point of marked weakness following any exertion. Six months before entry she was seen by her physician who, on finding her to be anemic, gave her liver and iron injections at sporadic intervals for several months. The irregularity of her appearance at the doctor's office for these injections was occasioned by her inability to pay the physician and by a natural repugnance for charity.

There were some elements in her domestic life which must be pointed out here to understand their effect on her pre-psychotic personality and to note their undoubted contribution to the further progress of her disease. She was an intelligent, cultured and conscientious woman of a cheerful, though retiring, disposition. Her friends knew her to be a good mother, patient in the face of difficulties, even-tempered and gracious. She had at one time been well-off financially and had lived with her husband and two children in some of the better New York hotels. Her husband lost heavily during the depression, so that they were ultimately forced to sell most of their household possessions and to move to more modest quarters in a small Connecticut town. Thereafter, her husband became hopelessly inadequate as a family provider. He began drinking inordinately and during his bouts of inebriation would malign and beat her. He stole small pieces of her jewelry, which she had retained as remembrances of her home in Norway, and he pawned them for money to buy more liquor. At long last, the domestic relations were strained to the breaking point and she left with the two children.

Forced now to support the children by dint of her own labor, she moved from place to place seeking odd jobs. Finally, she came to Providence where she obtained work as a sales clerk in one of the large department stores. At this juncture, her symptoms of asthenia and lethargy began to develop. She was much concerned over the welfare of her two children — one of whom was a boy now in high school, the other a girl of grammar school age — and she felt a deep sense of obligation to work for them despite her impaired health.

During the year before admission to the hospital, she gradually developed puffiness of the eyes and face, her hair became coarse and lusterless and her skin assumed a dry, scaling appearance. She lost much of her axillary and pubic hair. Her mouth was continually dry and she became chronically constipated.

She found that she could no longer concentrate on figures in making out the sales slips at work. She became more and more tired, so that she was able to work efficiently for shorter and shorter periods during the day. When she went home at night, her only desire was to go to bed immediately, although a full night's rest did little to relieve her asthenia. Later, when her son joined the Navy, her sleep was disturbed by the constant worry over his fate in the war.

continued on next page

* Presented before the Providence Medical Association, October 4, 1948.

able to stand on her feet at the store. She was called to the manager of the store because her

During the week before entry, she was barely book-keeping accounts were out of order. This resulted in her thinking that the other sales clerks were spying on her and were reporting her to the office. She felt that people were watching her every move.

Her physical exhaustion reached its zenith on the day before admission. She left the department store early in the afternoon, but was completely amnesic regarding any of the events that followed. Her sister revealed that the patient went home and dropped on the bed, but several hours later became so delerious that she could not be managed at home. She thrashed about the bed wildly and had highly imaginative, visual hallucinations. She kept referring to a sundry group of people who were following her. Even on the way to the hospital in the ambulance, she believed that she was being taken to the State Mental Institution.

When first seen on the Medical Ward, she was found to be a well nourished woman with a yellow-tinged, waxy pallor to her skin. She was not then actively delerious, but was in good contact. She was extremely lethargic and spoke in a soft, slow monotonous voice. She had a typical myxedemic facies, her puffy eyelids with narrowed palpebral fissures giving it a Mongoloid expression. Responses to questioning were given after what seemed to periods of long deliberation and, although not accompanied by any facial show of emotion, her answers were always pertinent to the subject and rational.

Her forehead was furrowed with many fine wrinkles. The skin was dry, coarse and myxedematous, the most marked thickening ocurring over the forearms, hands and pre-tibial regions. Her scalp hair was dry and brittle, the lateral thirds of her eyebrows were absent and her axillary and pubic hair were greatly diminished. Her tongue was thick and appeared to augment the speech defect. The heart rate was 52, the sounds were very faint, but there was no evidence of enlargement and the rhythm was regular. The abdomen was distended and tympanitic. All the deep tendon reflexes were hypoactive and the muscles relaxed slowly after contracture. The rest of the examination was essentially negative.

Laboratory work revealed normal urinary findings. There was an anemia with a hemoglobin of 56% (8.7 Gm.), red blood cell count — 2,920,000, hematocrit — 26, mean corpuscular volume — 89 cubic micra, mean corpuscular hemoglobin — 29 micromicrograms, mean corpuscular hemoglobin concentration — 33 per cent. White blood count was 8,000, with a differential count of 68% polys and 32% lymphocytes. The BMR was minus 18% and the serum cholesterol 340 mg. An EKG showed low voltages in all leads. X-ray of the chest revealed the heart to be normal in size, shape, and position and there was no evidence of pulmonary pathology.

During the first night of her hospital stay, she became wholly irrational. She screamed without apparent cause at the nurses and other patients, occasionally with a great show of fear and apprehension. She attempted to get out of bed despite the presence of side-boards, and was completely disoriented as to time, place and person. She saw objects in quadruplet and once thought she saw black cars, like hearses, going by on the ward. This was succeeded by auditory hallucinations of various sorts. This delusory-hallucinatory state was not a continual affair, but came in spells followed by periods of relative sanity. She could predict the onset of one of these attacks by a sort of prodromal aura. The general noise and bustle of the ward would fade away from her perception and she would suddenly feel tense and insecure. She would be gripped by a great fear and at these times believed that she was going to die. She would call for her daughter that she might see her once again before dying. When the spells left her, she would become sheepish and profusely apologetic for causing trouble. It became necessary to move her to a single room because of the disturbance she created on the ward.

She was placed on four grains of dessicated thyroid extract by mouth per day in divided doses, and prostigmine and abdominal stupes for the abdominal distention. Adequate sedation was achieved with paraldehyde.

In four days she was well-oriented and had quieted down considerably. Her demeanor was improved, she was more alert, and her speech was quicker in tempo. Her pulse had come up to 80 per minute. Her skin was not as dry and the abdominal distention was relieved.

By the sixth day of therapy, she had improved sufficiently to be up and about. All her psychotic tendencies had disappeared and she was able to concentrate on reading and sewing for the first time in months.

On the fourteenth hospital day, a BMR was plus 5 per cent and the serum cholesterol was 160 mg. She was discharged on the 20th hospital day, at that time taking six grains of thyroid per day.

During the first two or three weeks of followup in the Medical Clinic, her only complaint was that of swelling of the ankles, which prevented her walking at any great length. A serum total protein was found to be 3.6 Gm. As it was felt that too great a quantity of "deposit protein" was being oxidized and eliminated with the current dose of thyroid extract, this was decreased to four grains per day.

After two weeks on this dosage and on a high protein intake, her serum protein came up to 9.6 Gm. and her ankle edema disappeared. Her hemoglobin rose to 82% and a red blood count was 4,150,000. The BMR was reported as plus 14 per cent. She was eating and sleeping well, had resumed most of her normal activities, and was completely asymptomatic.

SPINAL ANESTHESIA IN VAGINAL DELIVERIES

concluded from page 724

by an attendant who must watch and feel for the uterine contractions. We have found that in a posterior position, rotation is materially retarded. There is also some tendency for the retardation of spontaneous rotation in anterior positions but the relaxation of the soft parts facilitates forceps delivery. That there are certain dangers must be borne in mind at all times, but in the hands of a trained anesthetist, spinal anesthesia is definitely satisfactory. It gives a dramatic and effective relief to the discomfort of labor.

The simplicity of the technique[6] requires a minimum amount of paraphernalia. We copy Willis Brown in saying that with a relative amount of safety one can obtain the four freedoms of obstetrics:

(1) Freedom from labor pains

(2) Freedom from fetal asphyxia

(3) Freedom from the risks of an indwelling needle or catheter

(4) Freedom from constant physician attendance

There can only be freedom from fetal asphyxia[7] in regulated dosage of the anesthetic drug as we have attempted to do with our dosage table. Frequent blood pressure readings and prompt institution of treatment if there is a marked fall or if the systolic reading drops below 80 m.m. of mercury and fetal heart tones checked often and 100% oxygen administered if a bradycardia persists.

Our experience with low spinal anesthesia has led us to the belief that it is not practical as a routine obstetrical procedure because of the limitation of time or the relative shortness of its duration. It is, however, the method of choice in operative deliveries or in a vaginal delivery where the time factor does not extend over 1½ hours.

We feel that spinal anesthesia has a definite place in the obstetrician's armamentarium and that it is a safe procedure when administered by one who is fully aware of the possible dangers and is capable of combating them.

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NEW ENGLAND LEADERS

Two Rhode Island physicians have been honored this Fall with the leadership of New England specialty groups. Dr. George W. Waterman, vice-president of the Providence Medical Association, is the President of the New England Obstetrical and Gynecological Society, while Dr. Emery M. Porter, past president of the Providence Medical Association, is the new President of the New England Surgical Society.



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INTERNAL MEDICINE IN CENTRAL EUROPE

The following impressions are recorded as the result of what must be admitted to be anything but an adequate opportunity to observe the work of leading European clinicians in the field of Internal Medicine. The writer, during a stay of nearly three months in Munich, did, however, meet a number of physicians who had, before the outbreak of World War II, held professorial rank in medical schools in Hungary, the Ukraine, the Baltic States, Poland and elsewhere. He also became acquainted with a few German clinicians in the course of his work as a member of a five man medical Teaching Mission which was conducting two four-week refresher courses for physicians of the Displaced Persons of Western Germany and Austria. In the days when Friedrich Müller was probably the leading internist of Europe, Munich was, to a great extent, the Mecca of the physicians of the world. One of the pupils of this great teacher, Dr. Frederic Valentine, is Physician-in-Chief at the Altersheim Hospital where these courses were given. He was of the greatest help to the Teaching Mission, both in ward rounds and clinical discussions into which he entered with vigor and enthusiasm. One of his assistants, Dr. Daffner, was also a German, as was Professor Singer, pathologist to the hospital. It was also the privilege of the writer to assist Dr. Hanns Baur, another former pupil of Fredrich Müller, with the translation into English of a book which he has written. Thus it has been possible without pretending to make even a partial survey of medical progress or achievement, for the writer to gain certain impressions concerning European medicine which may be of some interest.

In considering this subject no description of medicine as carried out in the American, British or French installations in their respective zones need be included. Such medicine is but an extension of the facilities of the respective countries to their troops and other nationals in occupied territory. Uufortunately, contact between the medical officers of such installations and the local profession and the D.P. doctors is almost non-existent. It is true, however, that in Munich, certain of the medical officers of the 98th General Hospital of the U. S. Army were sent to the Altersheim to attend the demonstrations of Professor Singer, the pathologist. In general, it may be said that this Army hospital and, I am told, the 97th General Hospital in Frankfurt as well, are excellent examples of American medicine and are presenting to the

young officers assigned to their departments of medicine the opportunity to acquire an excellent training. They cannot, however, be considered as a part of European medicine, with which we are concerned.

In discussing medical problems with European clinicians one is led to believe that there is among them somewhat more respect for authority than is seen in the United States. By this I mean a tendency to accept a dictum if advanced by a professor of wide reputation even if not supported by an adequate basis of demonstrable fact. And on the part of such leaders of the profession one senses at times a tendency to slip into the realm of medical philosophy and to advance an hypothesis because it is attractive and offers an excellent explanation of the problem in hand. This tendency is by no means universal, nor is it, one must admit, limited to Europeans. On the whole, however, one is, I believe, justified in the statement that a strict reliance on careful observations and an unwillingness to theorize far beyond reasonable conclusions based on such observations is less the rule in Europe than in America.

When applied to the clinic the result of such a tendency is exemplified in the wide use of hormonal preparations in a manner which is familiar to the American physician only as the practice of those of his colleagues here whose honesty and sincerity he is inclined to doubt. An extreme example is the use of a preparation called "corhormone," said to be an extract prepared from the bovine fetal heart at a time before any cardiac nerves had been developed and therefore, so the theory goes, when the continuation of the heart beat was due to humoral stimulation. Such an extract, supposedly containing a "cardiac hormone" was given to aged patients with failing hearts. This was explained in good faith to the writer by a physician who had shown himself in general to be an able clinician.

The preference for injectable remedies is notable throughout Europe. This does not, however, include the use of any such quantities of intravenous fluids as are used in this country (which suggests, as mentioned by Dr. P. P. Chase in his article on German Surgery, that perhaps we may have gone to the opposite extreme.) Transfusions are used when needed, but not as frequently as is probably desirable, and the use of saline and dextrose solutions certainly seems to an American to be definitely insufficient. (This, in many hospitals, is partly due to a lack of supplies and equipment.) Hormones, vaccines and also some of the commoner drugs are, however, freely injected. In the treatment of congestive cardiac failure, for example, it is the common practice to use strophanthin intravenously, not only during the initial stages but also as routine maintenance dosage throughout the patient's stay.

In spite of these variations from what seems to us the normal in practice it is only fair to admit that the clinical work that we of the teaching mission observed was on the whole good. As far as basic training is concerned the average European clinician with whom we came in contact appeared to be well grounded. The routine laboratory procedures such as electrocardiography, roentgenographic studies, hematology, and biochemical tests of blood and urine seemed very adequate although certain examinations were being used that have been abandoned in this country.

Information as to medical advances in the United States and elsewhere is gradually reaching the European clinician. Besides the Medical Missions which have visited university centers during the past three summers and our own courses given to D. P. physicians, a small and quite inadequate amount of material is copied in some of the European publications which are available. There is, however, a great need for the systematic distribution of American medical journals among physicians both in the D. P. and native groups.

Certain comments on the work in specific fields may be worth while. In cardiovascular disease, for example, one can say that electrocardiography and roentgenological studies were excellent. The importance of sodium restriction, however, in congestive failure had not been appreciated. In the same way the newer work on nephritis, especially the appreciation of lower nephron nephrosis as a clinical entity, was something with which almost all the clinicians with whom we came in contact were not familiar. In the field of respiratory disease they were, on the whole, well informed and the work of the sanatorium for tuberculosis, which it was our privilege to visit, seemed to us to be excellent and up to date. Diseases of the liver, especially the role of proteins and lipotropic substances was quite unfamiliar to them. Their knowledge and treatment of infections, particularly the so-called "contagious" group, appeared to us particularly confused. With certain prophylactic procedures they are thoroughly familiar. (The work on B.C.G. for example, has been carried much further in Europe than in this country.) On the other hand their isolation of patients with contagious disease, their "medical asepsis," is so crude as to be almost non-existant. Sulfonamides are available and also penicillin, the latter in fairly adequate amounts. Streptomycin is also available for cases in which it is particulary needed—but the supply was, when we were in Europe, very limited. (These statements regarding these antibiotic and chemotherapeutic agents apply to the hospitals of the D. P. physicians who are supplied

continued on next page

through the International Refugee Organization and may not apply to the native clinics of the other European countries west of the "iron curtain.")

The picture is still confused. We have native medicine in Germany suffering from the results of political degeneration under the Hitler regime plus the effects of military defeat. We have inside Germany over 2400 D. P. physicians, many of them excellent clinicians, working under conditions of poor equipment and a lack of educational facilities. We have the universities throughout Europe struggling to re-establish their work on a high plane. The help that has been received from this and other countries has been valuable as far as it has gone, but much more is needed. The establishment of the World Health Organization of the United Nations and the independent World Medical Association is of good omen and should have the support of physicians throughout the world.

CASE FINDING IN TUBERCULOSIS

The realization that tuberculosis can be eradicated as a significant infectious disease has spurred all health organizations to greater effort to accomplish this goal more quickly. Mass surveying of population groups have aided greatly in revealing hitherto unsuspected sources of infection. Prior to the perfection of miniature roentgenology and mobile x-ray units, the survey of large groups was difficult and cumbersome to the degree that it was impractical on a wide scale. Now, thanks to the research in photofluorography, we have available an easy, practical, and economical method of discovering contagious cases and suspects. The programs conducted here and elsewhere have been for the most part, on a voluntary basis. As such they reveal that about 80% of the people in a survey area are cooperative. It is gratifying to know that those who refuse are allowed to exercise this freedom of choice; and are neither forced to be x-rayed or punished because of their decision.

The morbidity and mortality from tuberculosis has decreased steadily since before the availability of these newer adjuncts for detection. The ultimate goal will be accomplished anyway. These surveys should accelerate the attainment. We should not, therefore, make it a criminal offence to have tuberculosis. The objective must be accomplished by an increased awareness by each individual of his responsibility to his fellow-man. This may be more readily secured if each physician encouraged his patients to accept these services when available. It serves a good cause for one patient to hear another say. "I'm for it. My doctor says it is O. K." Let us have a universal agreement. Let no doctor discourage it.

With the detection of definite or suspicious tuberculosis, case finding takes on an even more important role. The suspicious case must be followed closely by sputum examinations, blood studies, and further x-rays until the presence or absence of actual disease is determined. This is the function of the private physician. If he does not wish to do it, it is his privilege to elicit the aid of a private consultant or to turn it over to public health authorities. In the actually diagnosed cases, again it is the function of the private physicians to examine their patients who are contacts. There is a prevailing feeling among some physicians that contacts do not need x-rays, if they have been examined and found negative. A greater disservice to a trustful patient cannot be performed than to perpetuate the illusion that he (or she) is free of disease because you (or I) do not discover pathological signs by stethescope or history. It is really mandatory for us as honest physicians to tell all contacts that a chest x-ray is absolutely necessary for appraisal of the pulmonary status.

Where there are many contacts expense may be a factor in wanting to limit the number of x-rays. This, however, is not justified since there are readily available free clinics for this service within reasonable distance of all.

We are to see more and more x-ray surveys of all segments of the population. These are necessary because medical science has been unable to discover any other efficient method of protecting innocent people from what can be a horrible scourge. We must cooperate.

CHANGES

Change is always with us and is to be anticipated. We must make provision for it accordingly but when it comes upon us unexpectedly and rapidly it can be exceedingly disconcerting. Two of our large hospitals have had disturbing examples of this recently. At St. Joseph's Hospital the medical department lost an outstanding man by the sudden death of Dr. O'Rourke and now within a few weeks Dr. Belliotti, a leader in hospital and society activities, has been taken away by death from the surgical service.

The Rhode Island Hospital has had even more upsetting developments in its professional economy. At the beginning of the year Dr. Burgess finished a brilliant service as Chief of Medicine. This was because of the age requirement and was anticipated. He had a worthy successor in Dr. Guy Wells but again death intervened. Like Guy Wells, Herman Lawson had great experience in hospital administration and much clinical acumen. But now after a few weeks the Veterans Hospital takes this strong man away. It is an excellent arrangement for the new institution but increases the depletion in the ranks of the older foundation. The latter is ex-

tremely fortunate to have such an experienced capable man as Marshall Fulton to carry on.

In the midst of these great losses in one leading department another fundamental part of the hospital has to adjust itself hurriedly to radical changes. The Pathological Laboratory has made striking advances in size, diversity, and quality under the leadership of Dr. Clarke. He has been singularly fortunate in having associated with him such an outstandingly able pathologist as Dr. Robert Williams. The entire staff has felt secure in its reliance on the knowledge and judgement of these two unusual men. Now Dr. Clarke has gone to St. Luke's Hospital, New York, and Dr. Williams leaves the Rhode Island Hospital to associate himself with Dr. Lawson at the Veterans Hospital.

At the best it will be hard for the hospital to adjust itself to the loss of all these brilliant men in such a short time.

CANCER CONFERENCE

The response of Rhode Island physicians to the first statewide cancer conference was most encouraging for the continuation of this type of concentrated educational program in future months. Sponsored by the cancer committee of the Society, by the R. I. Cancer Society, and by the State department of health, the Conference gave the busy physician an intensive one day symposium of cancer control procedures.

With the public thoroughly awakened to the threat of the disease, and with popular magazines devoting much space to discussion of it, every physician is faced with the necessity of keeping abreast of the latest information in cancer control. The committee of the Society is to be congratulated for the exceptional program it arranged, the visiting speakers for their fine presentations, and the physicians who attended for their support and interest as indicated by the sizeable attendance.

RHODE ISLAND HOSPITAL STAFF DINNER

A few years ago the Rhode Island Hospital started the pleasant custom of Staff dinners. The one held at the Narragansett Hotel on Tuesday, November sixteenth was, as the others all have been, a success. A few libations opened the evening and prepared us for an excellent dinner after which Dr. Frank W. Dimmitt, President of the Staff Association, with well chosen remarks, turned the meeting over to Dr. Marshall Fulton who presided with grace, dignity, and ease.

Dr. Oliver Pratt, Executive Director and Mr. Peter Gerry, the President of the Board of Trustees, spoke. The latter also carried out the felicitous custom of presenting certificates to the retired chiefs of staff.

Then Dr. Fulton in a burst of poetic ardor introduced Dr. Alex Burgess through the medium of interesting and delightful rhyme. With the descriptive, philosophical acumen of a Samuel Butler or Alexander Pope there were enough technical details to show he was a fellow professional with John Keats, Oliver Goldsmith and Oliver Wendell Holmes. We are including in this Journal the authorized version.

Dr. Burgess told about the recent Medical Teaching Mission to Displaced Person Physicians at Munich, Germany, which he ably headed. His talk was an amplification of the article recently presented in the Journal of the American Medical Association by Drs. Findlay and Burgess. With the thorough marshalling of facts and clear straightforward exposition which we are accustomed to in his clinical talks he explained the situation of the large number of displaced doctors, the manner in which they had been carefully screened to prove their records and competence, and the excellent results which have followed their work in the camps and hospitals.

He stressed the calibre and enthusiasm of the choice group selected for this teaching course and gave in detail many incidents of the course all of which attested to the unusual high quality of this group of many nationalities.

His hearers got a vivid picture.

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WHAT GOOD ARE HEALTH MUSEUMS*

BRUNO GEBHARD, M.D.

The Author. *Bruno Gebhard, M.D., Director, Cleveland (Ohio) Health Museum.*

NEXT TO the weather, health and disease are the most talked about subjects. Women have their own ideas, right or wrong, of what is good for their health, for their husband's health and for their children's health, as does the male sex. There is a natural curiosity in everyone, child or adult, about the workings of the human body and about what makes them sick. There is no doubt also, that there is a small percentage of people with a morbid fear, but they are not made, they are born that way, with a mental make-up which makes them more introspective and sensitive to their physical reactions. Little can be done for them, and certainly nobody has as yet died of cancerphobia.

Sound health facts are based on the findings of human physiology and personal hygiene is nothing more than applied biology. Health education starts in the family and the first five years in our lives are the most important ones. It is during these years that we acquire our good and bad health habits and our likes and dislikes of certain foods. Children usually do not turn out much better than their parents; they are more or less "copycats". Expectant Mother, and so-called Expectant Father Classes are a good beginning of a modern parent education program.

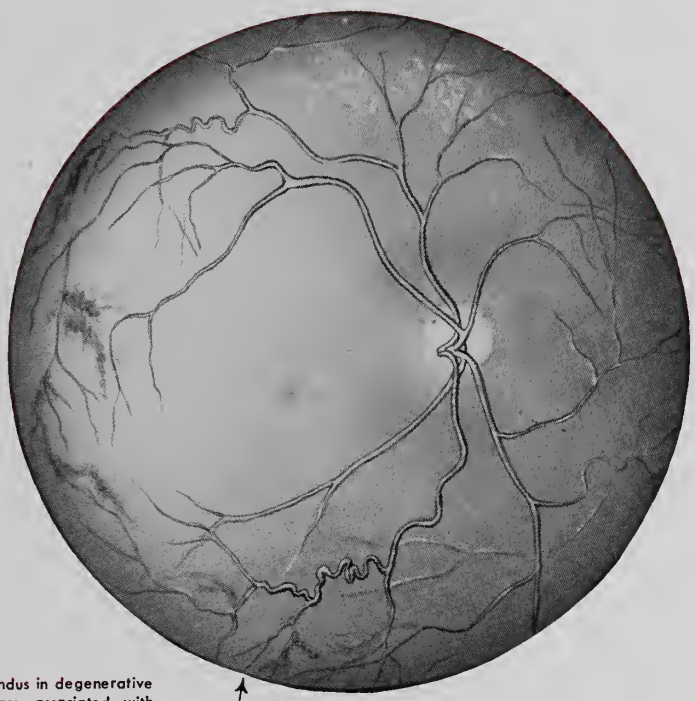
Health care is big business in every country. In this country especially, commercial advertising is the Number 1 Health Educator. Advertising uses the propaganda approach; it is successful only where it uses emotional appeal. Commercial advertising can be a good, but also a very bad health educator. It surely has been very effective in making the American people the greatest milk consumers and citrus fruit eaters; and if somebody cares to eat an apple a day, which makes 366 this year, there will be no objection. But there is also a negative side. Here is a very recent sample; a new method has been developed to reduce tooth decay forty percent. Local application of a fluoride solution at the ages of 3, 7, 10 and 13 years will reduce the number of cavities in children's teeth. This method is only effective after the dentist has cleaned and dried the surface of the tooth and by painting each tooth with the special solution. But, the public has already been offered commercial preparations such as tablets, dentrifices or mouth washes containing fluoride and claiming to be effective, which they are not as proven and stated by the American Dental Association. But fluoride treatments can only do half the job; tooth brushing and regular dental care is still needed and it is just as important to keep "the consumption of candy and other sweets to a minimum". This was so stated in an official pamphlet of the American Dental Association and the sugar industry promptly started to distribute material to the food editors of our newspapers saying that there is little or no relationship between sugar consumption and caries. We could tell a similar story on our profession regarding the indiscriminate use of aspirin, vitamin pills, and-so-forth. There may be no harm in their use, but they certainly represent an economic waste. Manufacturers of all kinds of products have even invented what has been called "advertising plagues". The January 9, 1948 issue of PRINTER'S INK published a list containing more than 300 advertising diseases or plagues that were brought into the public spotlight so that a cure might be affected by the remedy offered for sale by the advertiser. These plagues, or advertising diseases "differ in one important respect from those that continue to baffle science and medicine — for they can be relieved or cured by proper doses of certain advertised products". The list is alphabetically arranged. Here are some samples of the lesser known ones;

Acid Blues	Mother Hubbard Ankles
Barn Odor	Nervous B. O.
Calendar Fear	Office Hips
Dermerosion	Pendulosis
Evening-gown Stretch	Quesy Stomach
February Gray	Reception Room Blues
Goo	Stay-home-itis
Hi-tense-itis	Too Frequent Elimination
Intestinal Fatigue	Undie Odor
Jittery Nerves	Vacation Knees
Knuckle Grime	Whiskitosis
Lime Scum	Yawning Time

The gullibility of the people seems to be unlimited, and there is little help to be expected from those who quickly say "there should be a law against it". It takes sound, long-range, planned and con-

continued on page 734

*Presented before the Woman's Auxiliary of the Rhode Island Medical Society, at Providence, November 10, 1948.



Changes in fundus in degenerative vascular disease assaciated with arteriasclerasis, hypertensian and diabetes mellitus.

Tartuaus veins and arteries, with the latter varying in caliber, are part of the fundus findings af arteriasclerosis and hypertensian.

White areas af exudatian are seen. Hemarrhagic areas are alsa present in this fundus, and may be assaciated with generalized arteriasclerasis, hypertensian and diabetes mellitus.

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

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WHAT GOOD ARE HEALTH MUSEUMS

continued from page 732

tinued popular education to change the knowledge, the habits and the atttitudes of people regarding the care of health, the prevention of disease and the prolongation of life.

We have mentioned parents as health educators; we have somewhat critically surveyed business using radio and newspapers as health educators; there are the life and accident insurance companies which have contributed in a very positive way to mass education; there are the many voluntary health organizations, the official health departments, and there are, last but not least, the teachers in the schools who practice health and physical education day in and day out. Where does the medical profession enter into the picture?

The Doctor as a Health Educator

The good doctor is always a health teacher as far as the individual patient is concerned. Eighty percent of the work in pediatrics is education of the mother and the same is true for mental hygiene and psychiatry. Whether the patient has diabetes or tuberculosis, he cannot be treated without individual counselling and education. So far so good. But where the organized medical profession has been slow is in community health education. There are two reasons for this state of affairs. Public health has become, in the last thirty years, a separate technical profession having its own plans and policies which are not always in accord with organized medicine. This is something to be expected in modern society but it surely calls for an active program of public relations.

The shortage of physicians is another reason for the slow-down in community health education projects sponsored by the medical profession. The Bureau of Health Education of the American Medical Association has a great history in its effort and certainly is very much up-to-date in its present activities, using radio and television. But, we need more local activities to reach the mass of the people. Health education has to be guided and stimulated by the medical profession or it will be controlled by lay groups and commercial interests which often might not be in accord with what we feel is best for the people's health. In awareness of the platform of the American Medical Association advocating "the principle that the care of the public health and the provision of the medical service to the sick is primarily a local responsibility", the Cleveland Academy of Medicine started out in 1936 with a new approach to community health education. In close cooperation with the Cleveland Health Council twenty-two civic bodies including museums, colleges, schools and the newspapers, were invited to study the advisability "of establishing a permanent museum of health and hygiene where scientifically prepared material of a visual nature might be made available to the public at all times".

Role of Health Museum

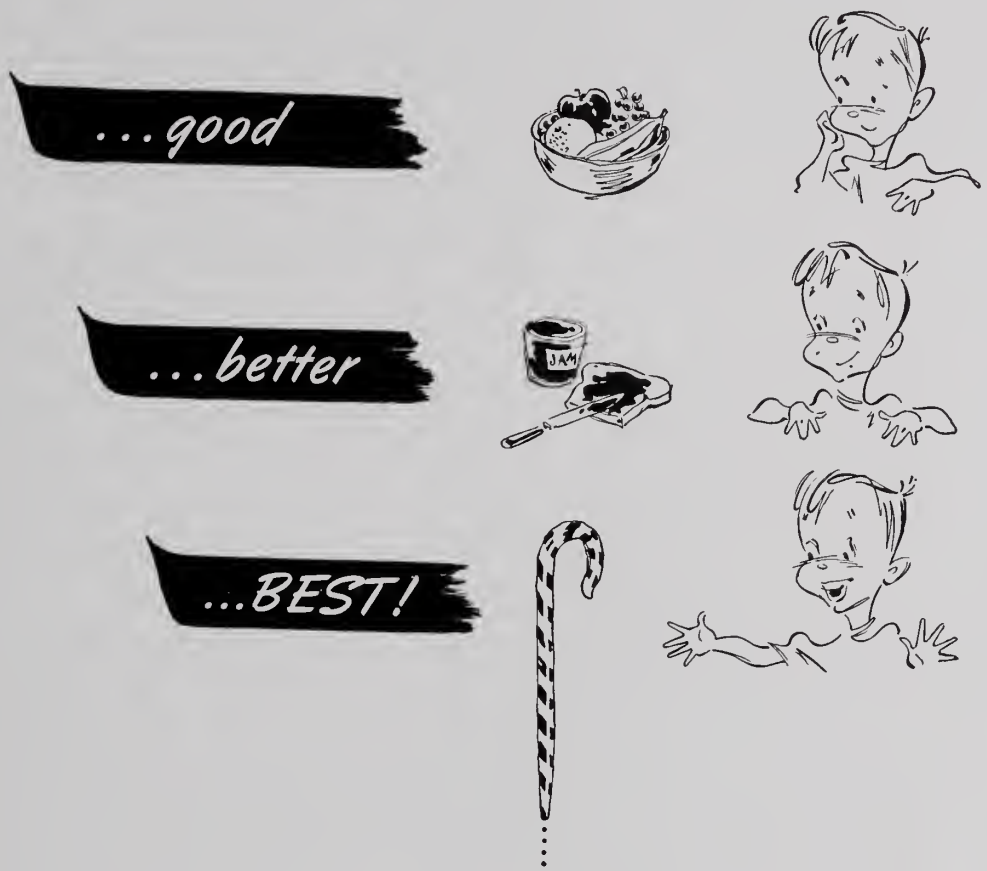
Health Museums are science museums specializing in human biology, personal and public health. They have preventive medicine as their father and health education as their mother. They address themselves more to the people than to the professional groups. Their emphasis is on normal growth and development, on the maintenance of health rather than on disease information and on hygiene of environment. They featured Man and his heredity, his development from his earliest stage to old age. As the present adult generation has received only a scanty biological education the Health Museum introduces Man to himself. Medical Museums feature disease; Health Museums aim at better health for more people, health being understood as being physically and mentally at ease.

The American public respects museums as places where one can find unbiased information; where nobody tries to "sell" anything other than true facts. Even in this country preventive medicine is overshadowed by the services of curative medicine, with great hospitals as their visible expressions. Health Museums can be developed as the natural bridge between curative and preventive medicine, and Health Museums may become the visual representation of public health. Health Museums are not an accumulation of collections; they are manufactured. They take their subjects from the natural sciences as well as the social sciences. The emphasis is on informal, objective, demonstrative teaching by the eye. "Things seen are mightier than things heard" (Tennyson). Wherever possible, health exhibits should be of a three-dimensional nature and animated or, even better, allowing visitor participation.

Timeliness of the exhibit's subjects is of great importance. Our "Special Exhibit of the Month" deals with seasonal subjects, as "Colds" in the autumn, Infantile Paralysis in July, Hay Fever in August; or they parallel national educational campaigns as those on Cancer, Venereal Diseases and Tuberculosis. They are on display for only that month which is designated to that special disease.

Our 15,000 feet of exhibit space are located on two floors of a remodelled three-story building, each floor having about 13 rooms. The ground floor has a small lecture hall with a seating capacity of 125, used mainly for the showing of films. A classroom seating 50 is used regularly for expectant mother classes and school groups; storage rooms for exhibits, a small kitchen used by woman's clubs in connection with monthly meetings, are also found on the ground floor.

continued on page 736



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WHAT GOOD ARE HEALTH MUSEUMS

concluded from page 734

Popular Exhibits

Following are some of the exhibits most popular with our visitors. Blood circulation is shown by a red light which travels the blood circuit when a switch is flicked on. A lever works the artificial lungs . . . a replica of the heart thumps out seventy-one heart beats a minute as a red light flashes each beat . . . the posture lady is poked into an ideal stance . . . a greatly enlarged photograph of the Cleveland Public Square shows how the blood cells of each human being, if stretched out, would cover the area of the downtown square. In another exhibit, the visitor moves the lever to change the heart beats for the various animals and fish, and learns the difference between the rate of man's heartbeat and those of the animal kingdom. In the "Wonder of New Life" room, life-size models of the Dickinson-Belskie series show the stages of birth, the growth of the embryo within the mother, the female and male organs. From these models adolescents learn the story of birth, expectant mothers learn how to prepare for their young. The Museum has the copyrights to these models, and is the only institution allowed to reproduce them for other organizations. In the dental room the "Transparent Tooth" gleams at the far end of the room, a triumph of artistry and accuracy. It shows in detail the anatomy of the average tooth. In another dental model, three hands, operated by a crank, show the proper way to brush the teeth. Turning another crank shows how and when baby's teeth will erupt in the mouth. Pushing a button shows what happens when just one tooth is lost. There are many exhibits in the room, "Food for Health". One, the "Calory Automat" is a guessing game where everyone finds, to his horror, that two doughnuts and a cup of coffee add up to 500 calories and an apple pie a-la-mode has 630 calories.

Our emphasis on visual means of communication does not, of course, exclude the use of the spoken and printed word. Guided tours, followed by one or two short film showings, take place regularly; a five minute radio program is on the air three times a week; TONE, the Museum publication, is published monthly; MAKING HEALTH VISIBLE is published, in its second edition, for professional readers, giving our basic philosophy and illustrating our techniques.

Our visitors come from all walks of life, more than half of them are adults, coming as a family. It is hard to say whether our 45,000 visitors per year represent a reasonable slice of our community — Greater Cleveland has one and one quarter million people. A special study is planned to analyze visitors' reactions and what they really get out of it. We have about five to six hundred groups coming annually, of which two-thirds are students of junior and senior high-schools.

A Community Organization

We do have outside activities. We do not wait for people to come to the Museum, however; we go to them with our loan and travelling exhibits. Voluntary and official health agencies outside of Cleveland use our loan exhibits at county fairs and at other occasions, or secure duplicates of our exhibits for permanent display. A health museum should take an active part in all community affairs so far as public health is concerned. Out of our short history one example might be mentioned. At the request of the Cleveland Welfare Federation the Museum designed a series of popular exhibits on geriatrics under the title "Live Long and Like It." A hobby and handicraft show augmented the educational exhibits, with 235 exhibitors; minimum age for participants was 65 years—the oldest being 89 years of age. More than 1,200 items were on display. It was the general opinion that this participation has helped in "mental rehabilitation" of the aged. So successful was the project that it became an annual affair.

Health Museums are the best means of cooperative advertising for the medical profession, if I may use the language of business and trade organizations. Good health education generally has always and always will increase the demand for better and more medical care. It is very dangerous to educate the people ahead of the facilities the community has to offer. Education and service must go hand-in-hand. Those who are afraid that health education increases self-diagnosis and self-treatment should keep this in mind. About one-third of our population is looking to sources other than the medical profession for the treatment and care of their ills — limited practitioners, religious cults and plain quacks. But more important is the fact that the patient always makes the first diagnosis. It is still the realization of "something is wrong with me" that brings the patients into our offices. It is still up to the patient to take the advice of his physician and do accordingly; it is still the patient who has the last word whether, and what kind of treatment is applied to his ills. We know that intelligent patients will cooperate better with their physicians. Only where health education is insufficient or is given in a wrong way are hypochondriac tendencies or abnormal fears created.

Health education of the public is never finished. It has to adapt its methods and means to the changing times. Visual education, as centered in a Health Museum, has proved it effectiveness. Seeing is easier and more convincing than limited reading or hearing. Seeing is not only believeing, it is also relieving. Health Museums can show the way to better health for more people.

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United States Dispensatory, ed. 24, Philadelphia, J. B. Lippincott Company, 1947, p. 1194.

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1947 Year Book of General Therapeutics, Chicago, The Year Book Publishers, Inc., 1947, p. 258.

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PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held at 6:30 p.m. on Thursday, October 21, 1948, in the Nurses Dining Room of Memorial Hospital. This was a dinner-meeting and was called to order by the President, Dr. Earl Mara.

The application of Dr. Peter Campellone was reported as approved by the Standing Committee and will be submitted to ballot at the next regular meeting.

Reports from the House of Delegates were given by Dr. Mara and Dr. Fox.

The Secretary read a warning from the Federal Food and Drug Administration regarding a batch of procaine hydrochloride solution manufactured by C. B. Kendall Company, Indianapolis, which has caused necrotic reactions.

Also read was a communication from the Secretary of the Rhode Island Medical Society regarding the selection of a candidate for the General Practitioner's Award given by the American Medical Association. This was tabled.

The meeting then adjourned to the Nurses Auditorium where Dr. Bert Jeremiah, Chairman, introduced the speaker of the evening, Dr. Michael DeVito, Professor of Plastic Surgery, Georgetown University.

Dr. DeVito discussed carcinoma of the skin, congenital defects and reconstructions of soft and bony tissue, illustrating his remarks with a splendid series of colored slides.

An interesting and lively discussion followed with members of the Skin, Surgical, X-ray and Pediatrics Services submitting queries and quoting results from local clinics.

The meeting was adjourned at 9:15 p.m.

Thirty-two members attended.

Respectfully submitted,
KIERNAN W. HENNESSEY, M.D.
Secretary

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providenec Medical Association was held at the Medical Library, on Monday, November 1, 1948. The meeting was called to order by President Philip Batchelder at 8:30 p.m.

By consent of those in attendance the reading of the minutes by the Secretary was omitted. There were no reports of committees.

The President announced that he was appointing a committee to prepare the Association's tribute to the late Dr. John Pinckney to consist of Dr. J. Murray Beardsly and Dr. Elihu S. Wing.

The President reported that he was in receipt of a communication from the Friends of Exeter School asking him to notify the members of the Association relative to the proposed referendum to be voted on November 2 for a bond issue for the extension of the facilities of the school. He briefly reviewed the specific purposes of the bond issue.

The first speaker of the evening was Mrs. John Langdon, Executive Director, of Crippled Children and Adults of Rhode Island, Incorporated. Mrs. Langdon briefly outlined the development of the Meeting Street School as a Cerebral Palsy Center and she then showed a motion picture depicting the activities carried on at the school.

After the showing of the motion picture Mrs. Langdon explained how her organization was prepared to work in cooperation with the medical profession.

The second speaker was Dr. Meyer Saklad, Chief of the Department of Anesthesia, Rhode Island Hospital, who reported on the "MEDICAL MISSION TO POLAND AND FINLAND" of which he was a member. He discussed the medical conditions in the countries of Europe that he had visited and he described some of the educational work that was carried on by the mission. His talk was concluded with the showing of many colored lantern slides taken while on his trip.

The meeting adjourned at 10:05 p.m.

Attendance 115

Collation was served.

Respectfully submitted,
JOHN E. FARRELL
Executive Secretary



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MEDICAL LIBRARY NOTES

THE LIBRARIAN of the Rhode Island Medical Society announces the recent addition of the following books:

ANTIBIOTICS

Donald G. Anderson & Chester S. Keefer—*The Therapeutic Value of Penicillin.* Ann Arbor, 1948. Edwards Brothers.

Chester S. Keefer & William L. Hewitt—*The Therapeutic Value of Streptomycin.* Ann Arbor, 1948. Edwards Brothers.

Perrin H. Long — *A-B-C's of Sulfonamide and Antibiotic Therapy.* Saunders. Phil., 1948.

CONGENITAL MALFORMATIONS

Douglas P. Murphy—*Congenital Malformations.* 2nd ed. Lippincott. Phil., 1947.

LABORATORY METHODS

R. B. H. Gradwohl — *Clinical Laboratory Methods and Diagnosis.* 4th ed. 3 vols. Mosby. St. L., 1948

NERVOUS SYSTEM

W. K. Livingston—*Pain Mechanisms.* Macmillan. N. Y., 1947

Joseph J. McDonald & others—*Correlative Neuroanatomy.* 4th ed. rev. University Medical Publishers. Palo Alto, 1948.

NUTRITION

Maladie de Famine. Récherchés Cliniques sur la Famine Executèes dans le Ghetto de Varsovie en 1942. Varsovie 1946. Gift of the American Joint Distribution Committee.

Symposia on Nutrition of the Robert Gould Research Foundation. Vol. I. Nutritional Anemia. Edited by Arthur Lejwa. Cincinnati, 1947.

POLIOMYELITIS

Collected Reprints of the Grantees of the National Foundation for Infantile Paralysis, 1947, Vol. VIII. N. Y., 1948. Gift of the Foundation.

RADIOLOGY

Fred J. Hodges & Ira I. Kaplan, editors—The 1948 Year Book of Radiology. Year Book Publishers, Inc. Chic., 1948.

SERIALS

Index Catalogue of the Library of the Surgeon-General's Office, U. S. Army (Army Medical Library) 4th ser., Vol. X, M1 (M-Mez). Wash., 1948. Gift.

Transactions of the American Clinical and Climatological Association. Vol. 58 (59th, 1946), 1947; Vol. 59 (60th, 1947), 1948. Gift.

Gifts of books and journals were received from Doctors Carney, Corrigan, Kramer, McWilliams, Welch and Wilcox and from the Peters House Library, the Providence Lying-In Hospital, the Providence Public Libary and the Rhode Island State Library Extension.

BOOK REVIEW

CONGENITAL MALFORMATIONS

Douglas P. Murphy, M.D. Second edition, 1947. J. B. Lippincott Co.

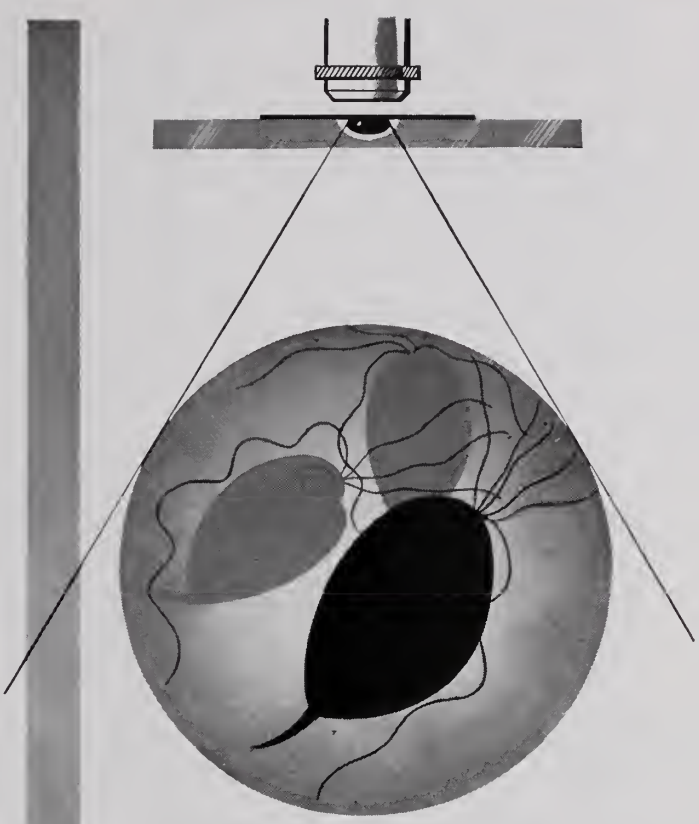
It has been customary, in comforting the unhappy mother of a congenitally malformed child, to assure her that she is perfectly safe in proceeding to have another baby, in view of the extreme rarity of a recurrence. This little volume completely dispels this comfortable delusion. In an extensive statistical study, Doctor Murphy, whose interest in this subject goes back more than twenty years, conclusively shows that the chance of having a second malformed offspring is 25 times greater than in the general population. Instead of the usual incidence of one in 213 births, it subsequently becomes one in eight births. There are records of a number of families where as many as four children have manifested the same or various other malformations.

That these defects are genetic in origin is abundantly demonstrated, except for two environmental factors, vis: fetal irradiation in utero and maternal rubella, occurring in pregnancy. While the evidence for rubella is considerable and convinces Doctor Murphy, generally it is not accepted as proven, nor would all accept his dictum that therapeutic abortion is always indicated under these circumstances.

Making this book of even greater interest locally is the fact that the Providence Lying-in Hospital and the Glasgow University Hospital in Scotland, report the highest incidence of congenital malformations in the world. Obviously this high incidence, like that of diabetes in Massachusetts and Rhode Island, is due solely to diligent search and complete reporting.

CHARLES POTTER, M.D.

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In Regard to Displaced Persons

We are proud, Doctor Burgess, upon this occasion,
To give you a greeting—indeed, an ovation.
To welcome you back from a far distant place.
Where you went with our own Peter Pineo Chase.

* * *

We admire the spirit that took you to Munich,
To don there with Peter, the mantle and tunic
Of teacher, professor, advisor and friend,
To docs whose misfortunes are world without end.

* * *

We are glad, Doctor Burgess, you've returned to the fold,
To the land of your birth, where the Democrats bold
Have averted becoming displaced persons,
While our sense of security worsens and worsens.

* * *

I'll tell you just what I refer to by that,
One wonders if now at the drop of a hat
The Washington boys with an itch and a tingle
Won't drag out that bill by old Murray and Dingell.

* * *

This bill fraught with such psychiatric elation
To improve, over night, the health of the Nation,
Would land us docs as a professional class
Midway between supine and flat on our————.

* * *

You have seen how it worked in some places that tried it,
Please tell us how you'd like to live right inside it.
Perhaps we're alarmists, but I tell you true,
I'm worried about what this Congress will do.

* * *

The costs of a sickness have gone up so high
That for many a person, it's cheaper to die.
While business stays good, we at least can give thanks
That sick folks still have got some cash in the banks.

* * *

What gives me the jitters is what our profession
Will do if there happens to come a depression,
And folks can't afford $15 a day
For a room on Ward G or a bed on Ward K.

* * *

The crux of the matter is not that we docs
Don't give adequate care to the indigent crocks,
The rub comes because every Tom, Dick, and Harry,
Can't be sick and have plenty of dough left to marry.

* * *

The public don't care what will happen to us
In trying to settle this fuming and fuss,
What the government wants is good care for the millions,
To hell with the cost — even billions and billions.

* * *

No one will deny that's a worthy objective,
The important decision is, "What's the corrective?"
The question to settle when stripped to the bone
Is that we don't throw away bread for a stone.

* * *

We'd better admit that the pressure is heavy
To run our profession by government levy
I think we'd be wiser to give help and guidance,
Than buck things with loud and apposing connivance.
Alex Burgess, you've gone to the top of the tree
With your place on The Board of the College of P——.
You should utilize now your influence and weight
In helping avoid a calamitous state.

* * *

You should help Oscar Ewing and Barney Baruch
And indeed Harry Truman and Fishbein — the Duke
To see that some sensible conciliation,
Must come, lest we ruin the health of the nation.

* * *

Join up with your confreres in high standing places,
And go down to Washington, show them your faces,
And tell them, "Don't push this thing through over night,
If we must have State Medicine, let's have it right."

* * *

There's no time to go easy, or carry a stick
Somebody must do this, and must do it quick
Before our high standing as docs is erased
And we too become among Persons Displaced.

ELECTED TO COLLEGE OF SURGEONS

At the convocation of the College of Surgeons, held in Los Angeles in October, the following Rhode Island physicians were received into Fellowship: Dr. M. Osmond Grimes of Newport, Dr. Edmund C. Laurelli of Pawtucket, and Drs. Jack Savran and Carroll M. Silver of Providence.

MALPIGHI MEDICAL CLUB

The regular monthly meeting of the Malpighi Medical Club was called to order by its President, Dr. Frank D. Fratantuono, at 9 p.m. on October 26, 1948. The minutes of previous meetings were read and accepted.

A communication from Professor Forni of the Department of Surgery at the University of Bologna, Italy, was read to the members. He inquired as to the possibility of obtaining from the club an anesthesia apparatus similar to the one donated to Professor Dogliotti of Turin University.

A motion was made and passed empowering the President to authorize the purchase of a slide projector.

A motion was made and passed authorizing the President to appoint a new membership committee.

A discussion followed on the feasibility of the club holding a New Year Party.

The scientific portion of the meeting had Dr. Gaspar Angelo of Cambridge, Massachusetts, talking on "Office Procedures in Proctological Disorders". He illustrated his talk with some interesting colored slides. After discussion and a question period, the meeting adjourned at 11:15 p.m.

Collation followed.

E. Arthur Catullo, M.D.
Secretary

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SAMPLE STUDY OF CASH SICKNESS CLAIMS

Of a total of 2,645 recent claims for Cash Sickness Compensation which were the subject of a statistical analysis this month, (October), 1,924, or 72% were filed by workers engaged in manufacturing industries. As compared to this percentage the current figure of all manufacturing employees in the state is 55% of the total employment. A further breakdown showed that of the 1,924 industrial workers, 958, or 49%, were specifically employed by textile concerns. This figure is nearer to the state percentage of 41% of all industrial workers employed in textile work. Sixty-two different industrial classifications were represented in the total group of claims analyzed, forty-four, or 71% of them being non-manufacturing classifications which were represented by only 28% of the claims.

The figures and percentages shown in the analysis do not represent a cross section of all Cash Sickness claims. They are, rather, a sample study and therefore conclusions drawn from them must be subject to the limitations placed upon all sample studies. However, they do give a clear picture of the Cash Sickness Compensation claims which are currently active and indicate, even as a sample study, the source of claims being filed and the general characteristics of the claimants.

The analysis contains reports on six factors: (1) age groups, (2) medical diagnosis by broad groupings, (3) city and town, (4) benefit rate, (5) maximum credits and base year earnings, and (6) industry. Each breakdown supplies further information concerning the sex and marital status of claimants.

In the breakdown by age groups, 827 of all claims were concentrated in the twenty to twenty-nine year group. Six hundred and forty-one of these were female and of that number 405 were pregnancy cases. Of all claims filed by married women in all age groups, 47% were filed for benefits during pregnancy.

Of all claims analyzed, it was found that 65% fell into four major categories of illnesses. Twenty-two per cent were for pregnancy; eighteen per cent had suffered injuries or the effects of poisoning; fourteen per cent had diseases of the digestive system; and eleven per cent had diseases of the circulatory system. The remaining 35% were distributed among eleven other types of illnesses, with 7% shown as suffering from diseases of the nervous system and sense organs, including mental disorders.

It was determined that 1,127, or 43% of all claims were filed by males. Of the 1,518 filed by females, 1,223, or 81% were married. The average age of all claimants was 39 years with the average for males, 45 years, being ten years over that for the females. Only one-fifth of the male claimants in the group were under 30, while nearly one-half, or 49%, of the females fell into that age group.

Other analyses showed that the distribution of claims by city or town follows fairly closely the percentage distribution of workers throughout the state. The average potential weekly benefit amount of all cases analyzed was $17.25 with $17.59 for males and $16.99 for females. Average potential credits was $279. Six per cent of the total group had previously filed Cash Sickness claims in the current benefit year.

MONTHLY BULLETIN — Rhode Island Unemployment Compensation Board—Volume II—October 1948—No.6

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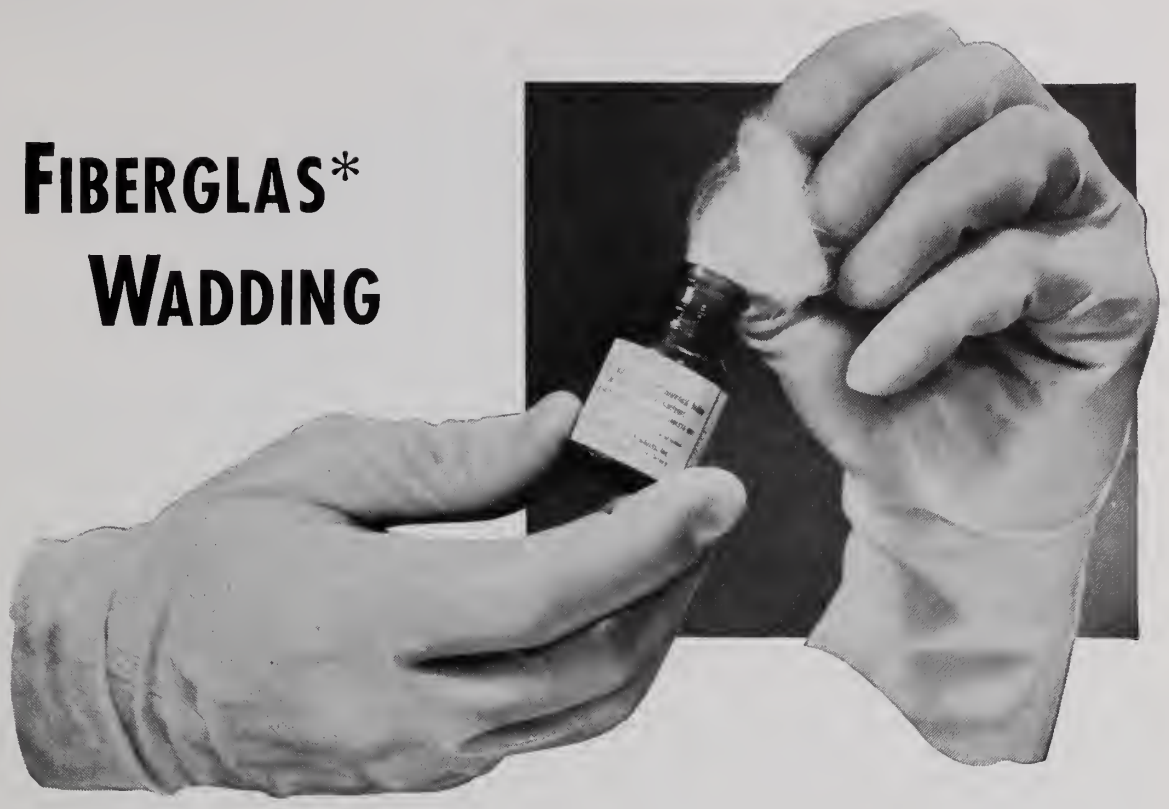


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BOOK REVIEWS

CLINICAL LABORATORY METHODS AND DIAGNOSIS, Vol. I

R. B. H. Gradwohl. Fourth edition. C. V. Mosby Co., St. Louis, 1948. pp 1295.

Same. Volume II—R. B. H. Gradwohl. Fourth edition.

C. V. Mosby Co., St. Louis, 1948, pp 1295 to 2284.

Same. Volume III—Gradwohl and Kouri. Fourth edition.

C. V. Mosby Co., St. Louis, 1948, pp 819.

This book, first published in 1935 as one volume, appears now, revised and brought up-to-date, as three large volumes of somewhat over 3,000 pages of text. Volume III is devoted entirely to Parasitology and Tropical Medicine. Since it has a joint author it has a separate index and separate paging. Volumes I and II have only one index in Volume II, though much time could be saved for readers if the index appeared in each volume.

There are many illustrations, a total of 1,169, of which 58 are in full color. The color plate opposite page 54 in Volume I is not very true, but in general the color plates are good.

It would be difficult for one person to judge such a collection of laboratory information. Volume I covers urine, blood, gastric analysis, puncture fluids, feces, and special tests such as allergy, mycology, and vitamin assay.

Volume II covers bacteriology, serology, postmortem examinations, tissue technique, museums, toxicology, crime detection, basal metabolism, and electrocardiography. Dr. Gradwohl acknowledges the help of several specialists in writing on such an array of subjects.

For each subject a brief historical outline is given, methodology or laboratory techniques are described, and this is followed by a discussion of the application of the results obtained in the laboratory to the diagnosis of disease. Alternate techinques have been described so that their difficulty and accuracy can be suited to the facilities and situation in most cases.

Phase microscopy, Rh types, antibiotic assay, thymol turbidity, and a discussion of blood cholesterol which leads to the conclusion that this determination is seldom of significant value, indicate an earnest attempt to have a modern revision. There is, however, no discussion of the war-gained significant advances in sub-fractionation of plasma or serum proteins, which may or may not be an important omission.

Inaccuracies, such as the statement that the chlorides of spinal fluid are about 740 mg. per 100 c.c., when the true value is less than 450, are bound to appear in such a lot of information, but very few were noted. Typographical errors were not noted so they too have been kept low.

This set of three volumes should be a valuable and comprehensive reference for every clinical laboratory, and could be read with profit by laboratory technicians, physicians, and clinical pathologists. Certain phases of its broad coverage are of interest to museum personnel, crime detection officers, public health officials, lawyers and judges, medical artists, dairy products manufacturers, and others.

RUSSELL O. BOWMAN, M.D.

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Further evidence of the safety of Benzedrine Sulfate therapy

More data, showing that Benzedrine Sulfate, in proper dosage, produced no toxic effects, have lately been published in a study by Caveness.[1]

He gave the drug for 14 consecutive weeks to 23 unselected hospital patients whose ages *averaged 65 years.* Daily dosages over the period ranged from 5 to 30 mg. The author observes:

"... no significant changes were noted in the cardiovascular, urinary, hematopoietic, or respiratory systems ..."

From this study, it would appear that Benzedrine Sulfate may be safely used in the treatment of depression in the aged.

1. New York State J. Med. 47:1003

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Who Have Business Telephone Service:

As recently announced, central office designations of telephone numbers will have a name and a figure effective with delivery of the next issue of the Providence and Vicinity Telephone Directory in the spring of 1949. For example, DExter will become DExter 1.

Except for WEst, present names and present figures and ring letters of numbers will remain the same. Thus, DExter 9984 will become DExter 1-9984, which will be dialed DE1-9984 and which will be spoken as, "Dexter One - Nine, Nine, Eight, Four."

In a change to dial service next winter, prior to the new designations taking effect, WEst will be replaced by ELmhurst and TEmple and figures in numbers in that area will be changed.

The following is a list of the new designations for the Providence operating area: CHestnut 1, DExter 1, EAst Providence 1, Elmhurst 1, GAspee 1, HOpkins 1, JAckson 1, MAnning 1, PLantations 1, STuart 1, TEmple 1, UNion 1, WIlliams 1. At the same time, central offices in neighboring areas will be similarly designated with a name and a figure, though not with "1" in every case.

While this new style of numbering is some time away, we believe you will appreciate this further notice about it so you can plan for changing any display you make of telephone numbers, such as in advertising matter, letterheads and forms, or on motor vehicles. It is very important that numbers in their revised form not be displayed until delivery of the new directory next spring, an exact time for which will be announced later.

With the new numbering style we shall be able to develop further service improvements, including long distance dialing by telephone operators. Also, by permitting one name to be used two or more times in combination with different figures, the new style provides for additional designations as required by growth, with the least possibility of having to introduce new names.

We shall be glad to furnish any further information you may desire.

John J. Halloran
District Manager



DRINK
Coca-Cola
TRADE MARK REG.

You trust
its quality

Experience is the Best Teacher



John William Ballantyne

(1861-1923)

proved it in obstetrics

BALLANTYNE, in his early studies of anatomical and pathological conditions found in the new-born, sensed the value of routine prenatal care in obstetrics. At the same time, other obstetricians were beginning to realize the necessity of greater attention during the ante partum period as a result of their investigations of eclampsia. It remained for Ballantyne, however, to be the first to establish a clinic for the expectant mother. World-wide acceptance of his concepts quickly followed Ballantyne's successful experiences in prenatal supervision.

R. J. Reynolds Tobacco Co., Winston-Salem, N. C.



EXPERIENCE IS THE BEST TEACHER IN CIGARETTES, TOO!

Yes, experience *is* the best teacher in choosing a cigarette! Millions of smokers who have tried and compared many different brands of cigarettes have found that Camels suit them best.

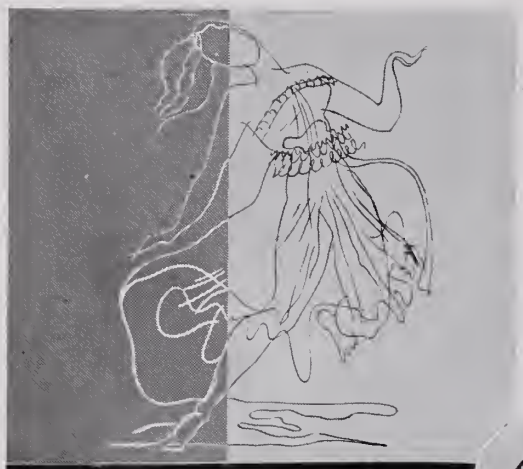
Try Camels. See if your *own* taste doesn't appreciate the rich, full flavor of Camels. See if your *own* throat doesn't welcome Camel's cool, cool mildness.

Let your own experience tell you why, with scores of smokers who have tried and compared, Camels are the "Choice of Experience."

According to a Nationwide survey:

More Doctors Smoke CAMELS than any other cigarette

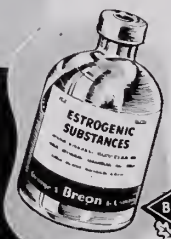
In a nationwide survey by three independent research organizations, 113,597 doctors were asked to name the cigarette they smoked. More doctors named Camel than any other brand.



Estrogenic Substances Oil Solution BREON

Oil solution in ampuls of 2,000 and 10,000 I. U. per cc and multiple dose vials of 10,000 and 20,000 I. U. per cc.

Aqueous suspension in ampuls and vials of 20,000 I. U. per cc.



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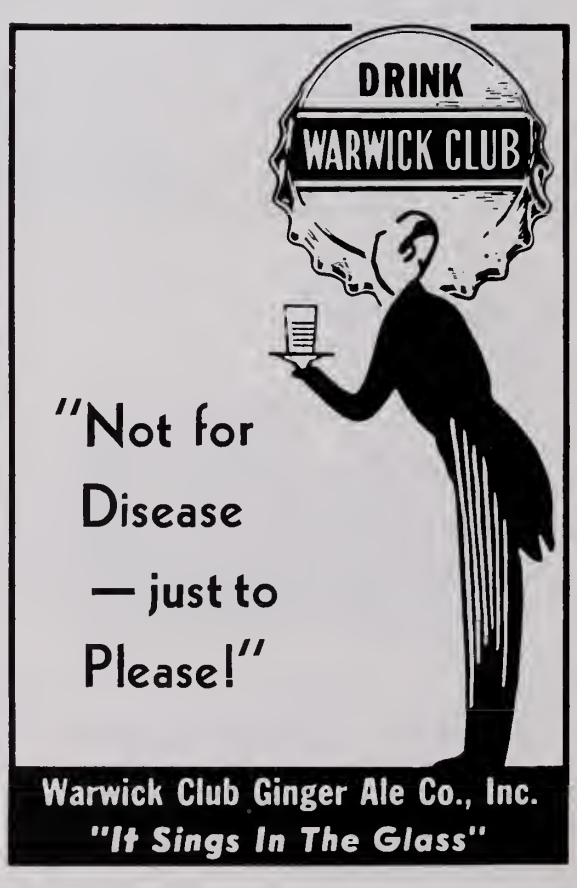
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• HIGH PATIENT-ACCEPTANCE—
Palatability and adaptability to a variety of vehicles (milk, juices, soups, desserts, etc.) encourage continued patient-acceptance of the supplement. New large-size packages afford convenience and economy.

SUPPLIED: In bottles containing 6 oz., and in 1-lb., 5-lb., and 10-lb. containers.

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Telephone: { WIlliams 7373 / UNion 0070

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(Diplomate of American Board of Internal Medicine; Internal Medicine and Cardiovascular Disease)
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82 Waterman Street, Providence
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RESIDENCE: Warren 1191

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WILLIAM B. COHEN, M.D.
Practice limited to Dermatology and Syphilology
Hours 2-4 and by appointment-Gaspee 0843
105 Waterman Street Providence, R. I.

F. RONCHESE, M.D.
Practice limited to Dermatology and Syphilology
Hours by appointment. Phone GA 3004
170 Waterman St. Providence 6, R. I.

VINCENT J. RYAN, M.D.
Practice limited to Dermatology and Syphilology
Hours by appointment Call GA 4313
198 Angell Street, Providence, R. I.

CARL D. SAWYER, M.D.
Practice limited to Dermatology and Syphilology
Hours by appointment
184 Waterman Street Providence, R. I.

BENCEL L. SCHIFF, M.D.
Practice Limited to
Dermatology and Syphilology
HOURS BY APPOINTMENT
Blackstone 3175
251 Broadway, Pawtucket, Rhode Island

MALCOLM WINKLER, M.D.
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Hours by appointment Call DExter 0105
199 Thayer Street, Providence, R. I.

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Ear, Nose and Throat
Otorhinologic Plastic Surgery
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FRANCIS L. BURNS, M.D.
Ear, Nose and Throat
Office Hours by appointment
382 Broad Street Providence

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By Appointment
141 Waterman Street Providence 6, R. I.
GAspee 6336

JOS. L. DOWLING, M.D.
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1-4 and by appointment

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By appointment
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DExter 2433

RAYMOND F. HACKING, M.D.
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105 Waterman Street Providence 6, R. I.

F. CHARLES HANSON, M.D.
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Providence 6, R. I. or GAspee 1600

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185 Washington Street West Warwick, R. I.
Hours by appointment Valley 0229

HERMAN A. WINKLER, M.D.
Ear, Nose and Throat
224 Thayer Street, Providence, R. I.
Hours by appointment Call GAspee 4010

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SIDNEY S. GOLDSTEIN, M.D.
Practice Limited to Diseases of the Nervous System
203 Thayer Street, Providence
Tel. DExter 5666

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Telephone: Plantations 5759
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Hours by appointment
102 Waterman Street, Providence, R. I.
Call JAckson 9090

PROVIDENCE MEDICAL ASSOCIATION

Annual Meeting

MONDAY, JANUARY 3, 1949

INDEX OF ADVERTISERS

	PAGE
Abbott Laboratories	735
Akalol Company	731
E. P. Anthony, Inc.	722
Ar-Ex Cosmetics, Inc.	744
Arlington Chemical Company	718, 753
Ayerst, McKenna & Harrison	713
Bayview Convalescent Home	743
Blanding & Blanding	746
Borden Company	712
J. E. Brennan & Company	743
George A. Breon and Company	752
Joseph Brown Company	731
Burroughs Wellcome & Co.	739
Butterfield Drug Stores	748
Camel	751
S. H. Camp Company	714
Casimir Funk Laboratories	709
Ciba Pharmaceutical Products, Inc.	705
Coca Cola Company	750
Curran & Burton	744
Davies, Rose & Co.	708
Doho Chemical Corp.	745
J. E. Hanger, Inc.	727
Langlais Health Institute	742
Eli Lilly & Company	insert 718-719
McCaffrey, Inc.	742
McKesson and Robbins, Inc.	707
S. E. Massengill Company	741
Mead Johnson & Company	Back Cover
Medical Milk Commission	753
Merck & Co. Inc.	717
A. B. Munroe Dairy	718
Mutual Benefit Health and Accident Association	706
Narragansett Brewing Company	inside Front cover
Neland Pharmaceuticals, Inc.	752
Owens-Corning Fiberglass	747
Parke Davis & Company	inside back cover
Physicians Directory	754-755
R. I. Limb Company	743
Schenley Laboratories, Inc.	715
Schering Corporation	737
G. D. Searle & Company	733
Smith-Holden, Inc.	710
Smith, Kline & French Labs.	749
The Wander Company	716
Warwick Club Beverages	752
White Rock Bottling Company of Rhode Island	742
Winthrop-Stearns, Inc.	756

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In manifest vitamin deficiencies it is inadvisable and impractical to rely primarily on dietary correction. The deprivation of essential nutrient factors usually has existed for many years, and it is important to give adequate treatment in order to restore health promptly.

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3 IMMUNITIES CONCURRENTLY CONFERRED

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VITAMIN D has been so successful in preventing rickets during infancy that there has been little emphasis on continuing its use after the second year.

But now a careful histologic study has been made which reveals a startlingly high incidence of rickets in children 2 to 14 years old. Follis, Jackson, Eliot, and Park* report that postmortem examination of 230 children of this age group showed the total prevalence of rickets to be 46.5%.

Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

MEAD'S Oleum Percomorphum With Other Fish-Liver Oils and Viosterol is a potent source of vitamins A and D, which is well taken by older children because it can be given in small dosage or capsule form. This ease of administration favors continued year-round use, including periods of illness.

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The New York Academy of Medicine

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